Proposal for a Section 1915(b) Capitated Waiver Program
Waiver Renewal Submittal

MICHIGAN

9/25/2002 THROUGH 9/24/2004

US DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare and Medicaid Services

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PROPOSAL FOR A SECTION 1915(b) CAPITATED WAIVER PROGRAM
Waiver Renewal Submittal

Introduction

The waiver renewal submittal is for a State's use in requesting renewal of an existing Section 1915(b) waiver program involving Managed Care Organizations (MCOs), Health Insuring Organizations (HIOs) or Prepaid Health Plans (PHPs) that provide contracted services to Medicaid enrollees under their care.

The use of this waiver renewal submittal is voluntary. The purpose is to facilitate the waiver renewal process and, thus, minimize unnecessary and cumbersome paperwork requirements. The completion of this request, used in conjunction with State Medicaid Manual instructions at sections 2106-2112, should expedite the State's effort to request the renewal of an existing waiver and HCFA's effort to process the renewal request.

All waiver renewal requests under section 1915(b) of the Social Security Act (the Act) are subject to the requirements that the State document the cost effectiveness of the project, its effect on enrollee access to and quality of services, and its projected impact on the Medicaid program (42 CFR 431.55(b)(2)). This model section 1915(b) waiver renewal submittal will help States provide sufficient documentation in conjunction with a previously completed waiver application submittal for HCFA to be able to determine whether the statutory and regulatory requirements of section 1915(b) of the Act have been satisfied.

Please note the following qualifications: (1) this version of the capitated waiver renewal submittal does not include new requirements proposed for the Medicaid Balanced Budget Act (BBA) regulation for managed care. Once those regulations are promulgated in their final form, waiver renewal requests will need to document compliance with any new requirements the regulations may contain. (2) States must still have MCO contracts and capitation rates prior approved by their HCFA Regional Office.

HCFA staff will be glad to meet with the State, set up a conference call, or assist the State in any way in the completion of the application. States requesting the renewal of a waiver under only Sections 1915(b)(2), 1915(b)(3), or 1915(b)(4), or a combined 1915(b) and 1915(c), waiver should work with their HCFA Regional Office to identify required submission items from this format.

Instructions

This waiver renewal submittal builds upon the new 1999 format for an initial waiver request. It is essentially the same document, with two changes: each section now starts with a request for monitoring results from the previous two-year waiver period, and asks for changes proposed for the next waiver period. In the 1999 initial submittal we asked for a description of the waiver program. In this document we ask not only for the

program description for the next two years, but a description/confirmation of what occurred in the previous two years.

Each section now starts with one or more items under the heading “Previous Waiver Monitoring.” States are asked a couple questions (as appropriate to each Section). First, States are asked to identify any variance between what they said they would do in the last waiver application and what actually happened in the last two years. In a waiver renewal process, HCFA determines whether States adhered to the program descriptions and activities in the previous waiver application. Changes to the waiver program should not be made without obtaining HCFA approval for a modification to the waiver.

In some sections, a second question in “Previous Waiver Monitoring” asks for the results of monitoring various aspects of the waiver program over the previous 2-year waiver period. Please provide a summary of the State’s monitoring results, including any breakdown available by sub-populations (i.e., if you have different or additional monitoring for foster care or SSI children than TANF, please indicate).

Following “Previous Waiver Monitoring” is the subsection called “Upcoming Two Year Period.” Its purpose is to give the State the opportunity to describe the waiver program for the next two years. Within this section States are asked to identify any items which reflect a future change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") the item being changed.

Please fill out this form in its entirety. Since this renewal submittal builds on the new 1999 initial submittal, there is not a one-to-one correspondence between sections in this 1999 and the 1995 format. When filling out the “Previous Waiver Monitoring” part of each section, we have tried to identify corresponding sections of the 1995 format when possible. However, States should provide monitoring results from all relevant sections of their previous waiver.

Waiver Submittal Instructions (See State Medicaid Manual 2106)
Please submit an original and four (4) copies of the waiver request to the appropriate office:

For MCO and PCCM programs:

HCFA, Center for Medicaid and State Operations, FCHPG
Attn: Director, Division of Integrated Health Systems
7500 Security Boulevard
Baltimore, MD 21244

For Prepaid Health Plan programs focusing on Behavioral Health or Elderly and Disabled populations:

HCFA, Center for Medicaid and State Operations, DEHPG
Attn: Director, Division of Integrated Health Systems
7500 Security Boulevard
Baltimore, MD 21244

At the same time, send at least one copy of the waiver request to the appropriate HCFA Regional Office. A waiver request submitted under 1915(b) of the Act must be approved, disapproved, or additional information requested within 90 days of receipt, or else the request is deemed granted. The Secretary approves or denies such requests in writing or informs you in writing with respect to any additional information which is needed in order to make a final determination with respect to the request. When additional information is requested, the waiver request must be approved or disapproved within 90 days of receipt of your complete response to the request for additional information, or the waiver request is granted.

The 90-day time period begins (i.e., day number one) on the day the waiver is received by the addressee (i.e., the Secretary, the HCFA Central Office (CO) or Regional Office (RO) designee) and ends 90 calendar days later by which time HCFA must either approve or disapprove the request.

General instructions
States should check all items, which apply, and provide additional information when specified. Leaving an item un-checked signifies it is not in the State's waiver program. Please note the following:

- a number of the items are required by federal statute, regulation, or policy. These required items are identified as such either in the instructions or headings for a section, or on an item-by-item basis. State must check-off these required items to affirm the State's intent to comply. If a required item is not checked, States should explain why it is not.

- all items are applicable to both MCOs and PHPs unless otherwise noted (i.e. only MCO or PHP is referenced in the item)

- for any of the sections that require explanations, if possible, please insert them into the document itself instead of attaching the explanation as an appendix.

- Because this is for a renewal of an existing waiver, HCFA is requesting data or summary results from efforts the State has made during the previous waiver period to ensure compliance, quality of services, enrollee protections, etc. In an effort to ensure a complete submission package and to minimize the amount of additional information requested by HCFA, please be sure to respond to these items as fully as possible so that additional information requests are not necessary.

- If a State modifies the wording of the waiver renewal submittal, please italicize and/or strikeout the modification. States may use italics, underlines, and strikeouts for any State-added information or modification to the standard waiver renewal submittal.

- please update the table of contents prior to submitting the waiver to HCFA to reflect the current page numbers and appendices.

- please enclose any attachment directly following the section referenced and number the attachments with the section and question number, (e.g., Attachment C.I.a is the attachment for question a. under point I. Elements of State Quality Strategies in Section C.)

Amendments or modifications during the renewal period

During the renewal period, a State may wish to modify their Section 1915(b) waiver program if an aspect of the program changes. Four (4) copies of the modification request must be submitted to the appropriate CO address listed above. A copy should also be sent to the RO at the same time.

HCFA considers only waiver requests submitted by or through the Governor, State cabinet members responsible for State Medicaid Agency activities, the Director of the State Medicaid Agency, or someone with the authority to submit waiver requests on behalf of the Director.

HCFA reviews the request and makes its recommendation to approve or disapprove the request based on the validity of the request and the documentation that is submitted to support the modification. Approval of modification requests is effective from the date of approval through the end of the renewal period.

HCFA receives a variety of waiver modification requests, which range from being minor in nature to extensive. Regardless of the extent of the needed modification, a State must submit an official request for modification to HCFA as soon as it is aware of the need for a change in its program. The request must be submitted and approved prior to implementation of a change in the waiver program.

Section A. General Impact

I. Background

[Required] Please provide a brief executive summary of the State's 1915(b) waiver program's activities since implementation, including experiences during the previous waiver period(s) and a summary of any program changes either planned or anticipated during the requested renewal period. Please specify the types of stakeholders or other advisory committee meetings that have occurred in the previous waiver period or are expected to occur under the future waiver period. Please include descriptions of any advisory boards that have consumer representation. In addition, please describe any program changes and/or improvements that have occurred as a result of stakeholder involvement during the previous waiver period(s). Please describe any stakeholder involvement in monitoring of the previous waiver period. Finally, to the extent the State enrolls persons with special health care needs, please describe how the various stakeholders have been involved in the development, implementation, and ongoing operation of the program.

The implementation of Michigan's 1915 (b) Waiver Program, The Comprehensive Health Care Program, CHCP, was initiated in 1996 to institute "value purchasing" as the mechanism for addressing the following issues:

- **Access to Care**
- **Increased Medicaid expenditures**
- **Lack of accountability in the delivery service system**
- **Either lack of data or data indicating poor performance**
- **Customer services were cumbersome and inaccessible for many beneficiaries.**

The development and implementation of a competitively bid managed care program in 1997, 1998 and 2000 have resulted in the following accomplishments over the initial and first renewal period:

1. **Access to Care is assured for enrolled beneficiaries;**
2. **Accountability has been established and in place through contracts with Contracting Health Plans;**
3. **Costs are now predictable;**
4. **Performance of Contracting Health Plans is measured;**
5. **Customer satisfaction is achieved; and**
6. **Michigan's Program has been deemed successful by external auditing and oversight agencies.**

Details regarding the performance during the waiver period are included in the attachments to this waiver renewal request and will also be described

in the responses to specific questions. While the instructions indicated that attachments should follow each section, the attachments included are referenced frequently in multiple sections and are therefore included at the end of the package. However, a narrative description of issues has been included for each appropriate response.

<u>Note:</u> Because the Cost Effectiveness Analysis was being conducted concurrent with the development of other responses to the waiver renewal, Section D is included at the end of the Waiver Renewal Package. Also note that the State's response to each question is printed in bold print.

Specific CHCP implementation responsibilities will be described as that of the CHCP program rather than attributing them to a specific DCH section or division due to the recent reorganizations. Since the CHCP Waiver program involves contracts with HMOs the use of terminology MCO or HMO are used with the same meaning.

Michigan has attempted to implement the CHCP program consistently with the description submitted in previous waivers that were approved. Changes that have occurred are generally the result of improved operations, reporting, and data assessment, other than in alterations of prior approved objectives. Therefore there will be few responses included in sections of the waiver renewal format addressing "operational differences than described in the waiver governing that period. " Further, the intent of Michigan's CHCP program is to continue operating essentially the same program over the next waiver period with the following changes.

- **Michigan is seeking approval to administer a "rural exception" program based on the final BBA rules. Information and description for implementing a "rural exception" for mandatory enrollment requirement of at least two MCOs is included in this waiver renewal. The "rural exception" program will permit a more efficient administration of health care delivery while still providing choice of available providers in the selected rural areas of Michigan. (See Attachment X, Rural Exception Procedures).**

- **The Michigan Legislature has recently enacted a provider tax on HMOs. This is referred to as the Quality Assurance Assessment Program and will be used to help support the Medicaid program. Information on the implementation of the "tax" is included in this waiver renewal package within the Cost Effectiveness section. Separate Waiver amendments have been filed with CMS. The State of Michigan intends to implement this program consistent with federal requirements, including assurances that the "hold harmless"**

provisions are met. (See Attachment Z, Quality Assurance Assessment Program letter).

Finally, the CHCP program continues to seek consultation from different stakeholders who have an interest in the Medicaid program generally and managed care specifically. The DCH continues to meet with the Medical Care Advisory Committee (referred to as Health Plan Advisory Committee) and provide implementation information. This group meets quarterly and also receives information from the DCH between formal meetings including briefings regarding the intended changes to be reflected in the waiver renewal. Additionally, the DCH has conducted the following to solicit and implement views of various stakeholders:

- **Participated in a Robert Wood Johnson grant project to support the transition of adult Medicaid beneficiaries with disabilities into managed care. A key element of the project was collaboration between local Centers for Independent Living (CILs) and Contracting HMOs via three components:**
  - **Consumer competency and education**
  - **CIL/Provider interface (strengthening health plan capacities for serving persons with disabilities)**
  - **Healthcare advocacy (building consumer-oriented advocacy networks)**

The DCH collaboration continues with the agencies serving persons with physical or mental disabilities such as:

- **Michigan Association of Centers for Independent Living (MACIL)**
- **Michigan Disability Rights Coalition**
- **Michigan Rehabilitation Services**
- **Michigan Department of Career Development**

The enrollment services contractor, Michigan ENROLLS, provides on-going education and outreach to community agencies and encourages referral of special populations to call the Michigan ENROLLS call center or use field enrollment counselors. Michigan Enrolls also refers beneficiaries to the following agencies as appropriate and in some cases contacts the agency and request that the agency contact the beneficiary:

- **DCH mental health and substance abuse central office staff**
- **Local Family Independence Agency offices**
- **Local health departments**
- **Local Community Health Services Programs**

- **Parent Participation Line for Children's Special Health Care Services (CSHCS)**

The enrollment services counselors are given education on various special populations, such as CSHCS, recipient monitoring, mental health/substance abuse, and foster care. In talking with the beneficiary, the counselor can determine whether a direct referral is necessary or if a referral should be made to DCH for follow up.

DCH staff, including the CHCP Program, continues to provide frequent presentations for provider groups, health care coalition meetings, and consumer groups. The DCH has also developed information packages regarding the Medicaid Program and Managed Care program as part of the Michigan Virtual University—a web based interactive program that is linked to the MDCH website and is part of e-Michigan. A Description of their activities is included as Attachment EE, CHCP Communication Summary with Local Agencies.

II. General Description of the Waiver Program

Previous Waiver Period

a.___ During the last waiver period, the program operated differently than described in the waiver governing that period. The differences were:

Upcoming Waiver Period -- For items a. through m. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response.

a. T**he State of** Michigan requests a waiver under the authority of section 1915(b)(1) of the Act. The waiver program will be operated directly by the Medicaid agency.

b. **Effective Dates:** This waiver renewal is requested for a period of 2 years; effective September 25, 2002 and ending September 24, 2004.

c. **The waiver program is called** Michigan Comprehensive Health Care Program, CHCP.

d. **State Contact:** The State contact person for this waiver is Susan Moran and can be reached by telephone at (517) 241-7933, or fax at (517) 241-9950, or e-mail at morans@michigan.gov.

e. **Type of Delivery Systems:** The State will be entering into the following types of contracts with the MCO or PHP. The definitions below are taken

from federal statute. However, many “other risk” or “non-risk” programs will not fit neatly into these categories (e.g. a PHP program for mental health carve out is “other risk,” but just checking the relevant items under “2" will not convey that information fully). Please note this answer should be consistent with your response in Section A.II.d.1 and Section D.I.

1. X **Risk-Comprehensive (fully-capitated--MCOs, HIOs, or certain PHPs):** Risk-comprehensive contracts are generally referred to as fully-capitated and require that the contractor be an MCO or HIO. Comprehensive means that the MCO is at risk for inpatient hospital services and any other mandatory State plan service in section 1905(a), or any three or more mandatory services in that section. References in this preprint to MCOs generally apply to these risk-comprehensive entities. Check either (a) or (b), and within each the items that apply:

   (a) X The contractor is at-risk for inpatient hospital services and any one of the following services:

      i. X Outpatient hospital services,
      ii. X Rural health clinic (RHC) services,
      iii. X Federally qualified health clinic (FQHC) services,
      iv. X Other laboratory and X-ray services,
      v. ___ Skilled nursing facility (NF) services,
      vi. X Early periodic screening, diagnosis and treatment (EPSDT) services,
      vii. X Family planning services,
      viii. X Physician services, and
      ix. X Home Health services.

   (b) __ The contractor is at-risk for three or more of the above services ((i) through (ix)). Please mark the services in (a) and list the services in Section A.II.d.1.

2. ___ **Other Risk (partially-capitated or PHP):** Other risk contracts having a scope of risk that is less than comprehensive are referred to as partially-capitated. PHPs are the contractors in these programs (e.g., a PHP for mental health/substance abuse). References in this preprint to PHPs generally apply to these other risk entities. Please check either (a) or (b); if (b) is chosen, please check the services which apply. In addition to checking the appropriate item, please provide a brief narrative of the other risk (PHP) model, which will be implemented by the State:

(a)__ The contractor is at-risk for inpatient hospital services, OR

(b)__ The contractor is at-risk for two or fewer of the below services ((i) through (ix)).

i.___ Outpatient hospital services,
ii.___ Rural health clinic (RHC) services,
iii.___ Federally qualified health clinic (FQHC) services,
iv.___ Other laboratory and X-ray services,
v.___ Skilled nursing facility (NF) services,
vi.___ Early periodic screening, diagnosis and treatment (EPSDT) services,
vii.__ Family planning services,
viii.__ Physician services, and
ix.___ Home Health services.

3.___ **Non-risk:** Non-risk contracts involve settlements based on fee-for-service (FFS) costs (e.g., an MCO contract where the State performs a cost-settlement process at the end of the year). If this block is checked, replace Section D (Cost Effectiveness) of this waiver preprint with the cost-effectiveness section of the waiver preprint application for a FFS primary care case management (PCCM) program. In addition to checking the appropriate items, please provide a brief narrative description of non-risk model, which will be implemented by the State.

4.___ Other (Please provide a brief narrative description of the model. If the model is an HIO, please modify the entire preprint accordingly):

f. **Statutory Authority:** The State's waiver program is authorized under **Section 1915(b)(1) of the Act**, which provides for a capitated managed care program under which the State restricts the entity from or through which an enrollee can obtain medical care.

g. **Other Statutory Authority.** The State is also relying upon authority provided in the following section(s) of the Act:

1._X_ **1915(b)(2)** - A locality will act as a central broker (agent, facilitator, negotiator) in assisting eligible individuals in choosing among competing health plans in order to provide enrollees with more information about the range of health care options open to them. See Waiver Preprint Section A.III.B Enrollment/Disenrollment and Section 2105 of the State Medicaid Manual. This section must be checked if the State has an independent enrollment broker.

2.___ **1915(b)(3)** - The State will share cost savings resulting from the use of more cost effective medical care with enrollees by providing them with additional services. Please refer to Section 2105 of the State Medicaid Manual. The savings must be expended for the benefit of the enrolled Medicaid beneficiary.

Please list additional services to be provided under the waiver which are not covered under the State plan in Section A.III.d.1 and Appendix D.III. The services must be for medical or health-related care, or other services as described in 42 CFR Part 440, and are subject to HCFA approval.

3._X_ **1915(b)(4)** - The State requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards, which are consistent with access, quality, and efficient and economic provision of covered care and services. Please refer to Section 2105 of the State Medicaid Manual.

h. Sections Waived. Relying upon the authority of the above Section(s), the State requests a waiver of the following Sections of 1902 of the Act:

1._X_ **Section 1902(a)(1)** – Statewideness of Services—This Section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. **Depending upon Contracting HMOs and their provider networks, this waiver program may not be available throughout the State**.

2.X__ **Section 1902(a)(10)(B)** - Comparability of Services--This Section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope. This waiver program includes additional benefits such as case management and health education that will not be available to other Medicaid enrollees not enrolled in the waiver program.

3._X_ **Section 1902(a)(23)** - Freedom of Choice--This Section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted. That is, individuals enrolled in this program receive certain services through an MCO or PHP.

4.___ **Section 1902(a)(30)** - Upper Payment Limits--This Section of the Act require that payments to a contractor may not exceed the cost to the agency of providing those same services on a FFS basis to an actuarially

equivalent nonenrolled population. Under this waiver, a contractor may receive a capitation rate and any other applicable payment which may cause total payments to the contractor to exceed the upper payment limits for the capitated services in a given waiver year. The waiver must still be cost-effective for the two-year period. An example of a program with this waiver is a partial capitation program, where the State gives the capitated entity (or entities) a bonus (which in conjunction with the capitation payment exceeds the UPL) for reductions in Medicaid expenditures for high cost areas, but the State demonstrates cost-effectiveness on the basis that total waiver program expenditures are less than total without waiver program expenditures.

5.___ **Other Statutes Waived** - Please list any additional section(s) of the Act the State requests to waive, including an explanation of the request. As noted above, States requesting a combined 1915(b) and 1915(c) waiver should work with their HCFA Regional Office to identify required submission items from this format.

i. Geographical Areas of the Waiver Program: Please indicate the area of the State where the waiver program will be implemented. (Note: If the State wishes to alter the waiver area at any time during the waiver period, an official waiver modification request must be submitted to HCFA):

1.__X_ Statewide -- all counties, zip codes, or regions of the State have managed care (Please list in the table below) or

2.____ Other (please list in the table below):

Regardless of whether item 1 or 2 is checked above, please list in the chart below the areas (i.e., cities, counties, and/or regions) and the name and type of entity (MCO, PHP, HIO, or other entity) with which the State will contract:

Health Plan Name	Entity Type	Service Area
Botsford Health Plan	Comprehensive Medicaid-only MCO	Oakland (P), Wayne (P)
Cape Health Plan	Comprehensive Medicaid-only MCO	Macomb, Oakland, Washtenaw, Wayne
Care Choices HMO	Comprehensive MCO	Kent
Community Care Plan	Comprehensive Medicaid-only MCO	Allegan, Barry, Crawford, Ionia, Isabella, Kent, Mecosta, Missaukee, Montcalm, Muskegon, Newaygo, Oceana, Osceola, Ottawa, Roscommon, Wexford
Community Choice Michigan	Comprehensive Medicaid-only MCO	Alcona, Allegan, Alpena, Antrim, Arenac, Barry, Bay, Berrien, Calhoun, Cass, Charlevoix, Emmet, Genesee, Gladwin, Grand Traverse, Iosco, Kalamazoo, Kalkaska, Kent, Lake, Leelanau, Lenawee, Manistee, Mason, Mecosta, Missaukee, Monroe, Montmorency, Muskegon, Newaygo, Oceana, Ogemaw, Osceola, Otsego, Ottawa, Presque Isle, Roscommon, Saginaw, St. Joseph, Van Buren

Great Lakes Health Plan	Comprehensive Medicaid-only MCO	Alger, Arenac, Baraga, Berrien, Calhoun, Cass, Chippewa, Delta, Dickinson, Gogebic, Hillsdale, Houghton, Huron, Iron, Jackson, Lapeer, Lenawee, Livingston, Mackinac, Macomb, Marquette, Menominee, Oakland, Ontonagon, Saginaw, Sanilac, St. Clair, Tuscola, VanBuren, Wayne
Health Plan of Michigan	Comprehensive Medicaid-only MCO	Allegan, Barry, Berrien, Branch, Calhoun, Cass, Eaton, Genesee, Hillsdale, Jackson, Kalamazoo, Lenawee, Livingston, Monroe, Oakland, Ottawa, Sanilac, St. Clair, St. Joseph, Van Buren,
HealthPlus of Michigan	Comprehensive MCO	Bay, Clare, Genesee, Gratiot, Isabella, Lapeer, Midland, Oakland, Saginaw, Shiawassee, Tuscola
M-Care	Comprehensive MCO	Livingston, Washtenaw, Wayne (P)
McLaren Health Plan	Comprehensive Medicaid-only MCO	Clinton, Eaton, Genesee, Ingham, Lapeer, Ogemaw, Oscoda, Saginaw, Shiawassee
Midwest Health Plan	Comprehensive Medicaid-only MCO	Macomb, Oakland, Washtenaw, Wayne
Molina Healthcare of MI	Comprehensive Medicaid-only MCO	Alpena, Arenac, Bay, Crawford, Gladwin, Gratiot, Huron, Ionia, Iosco, Kent, Lake, Macomb, Manistee, Mason, Mecosta, Midland, Montcalm, Montmorency, Muskegon, Newaygo, Oakland (P), Oceana, Ogemaw, Oscoda, Otsego, Ottawa, Presque Isle, Roscommon, Saginaw, Sanilac, Tuscola, Wayne (P),
OmniCare Health Plan	Comprehensive MCO	Wayne
Physicians Health Plan (PHP) -Mid MI	Comprehensive MCO	Clare, Clinton, Eaton, Gratiot, Ingham, Isabella
Physicians Health Plan (PHP) -SW	Comprehensive MCO	Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, VanBuren
Priority Health	Comprehensive MCO	Allegan, Antrim, Benzie, Charlevoix, Emmet, Grand Traverse, Kalkaska, Kent, Lake, Leelanau, Manistee, Mecosta, Montcalm, Osceola, Otsego, Ottawa
Total Health Care	Comprehensive MCO	Genesee, Macomb, Oakland, Wayne
Upper Peninsula (UP) Health Plan	Comprehensive Medicaid-only MCO	Alger, Baraga, Chippewa, Delta, Dickinson, Gogebic, Houghton, Iron, Keweenaw, Luce, Mackinac, Marquette, Menominee, Ontonagon, Schoolcraft
The Wellness Plan	Comprehensive MCO	Genesee, Lapeer, Macomb, Muskegon, Oakland, Oceana, Shiawassee, Wayne

*The State should list the actual names of the contracting entities. Cost-effectiveness data should be submitted for every city/county/region listed here as described in Section D.

j. MCO Requirement for Choice: Section 1932(a)(3) of the Act requires States to permit individuals to choose from not less than two managed care entities.

1. _X_ This model has a choice of managed care entities.
   (a)__ At least one MCO and PCCM
   (b)__ One PCCM system with a choice of two or more Primary Care Case Managers (please use the PCCM preprint instead of this capitated preprint)

(c)_X_ Two or more MCOs
(d)___ At least one PHP and a combination of the above entities

2.___ This model is an HIO.

3._X_ Other: Please list the reasons for the request.
The DCH will implement a Rural Exception Option for beneficiary choice. This is requested under provisions of rule 42 CFR Part 438, Rule 438.52 (b), published on June 14, 2002. The CHCP Program has developed proposed procedures to begin implementation of a program option. These procedures include:

- **Selection of rural counties;**
- **Underlying Contracted Provider Base**
- **Assurances regarding out-of-network services and access to such services, including transportation;**
- **Commitment to have provider capacity to serve all eligible beneficiaries in selected rural counties;**
- **Procedures for notification of beneficiaries prior to implementation;**
- **Procedures for notification of beneficiaries regarding their choice of PCPs or Case Managers;**

All other requirements of the CHCP Contract will be expected to remain in place. The DCH will review the existing rates approved for Contracting HMOs to determine if any adjustments are necessary provided that such adjustments do not exceed 100% of FFS equivalent. Final implementation will take place through a contract change that will be provided to CMS prior to implementation. (See also, Attachment X, Rural Exception Letter).

k. Waiver Population Included: The waiver program includes the following targeted groups of beneficiaries. Check all items that apply:

1._X_ Section 1931 Children and Related Poverty Level Populations (TANF/AFDC)

2._X_ Section 1931 Adults and Related Poverty Level Populations, including pregnant women (TANF/AFDC)

3._X_ Blind/Disabled Children and Related Populations (SSI)

4._X_ Blind/Disabled Adults and Related Populations (SSI)

5._X_ Aged and Related Populations (Please specify: SSI, QMB, Medicare, etc.) That are not Medicare nor covered by other managed care programs.

6.___ Foster Care Children

7.___ Title XXI CHIP - includes an optional group of targeted low income children who are eligible to participate in Medicaid if the State has elected the State Children's Health Insurance Program through Medicaid

8.___ Other Eligibility Category(ies)/Population(s) Included - If checked, please describe these populations below.

9._X_ Other Special Needs Populations. Please ensure that any special populations in the waiver outside of the eligibility categories above are listed here (Please explain further in Section F. Special Populations)

i._X_ Children with special needs due to physical and/ or mental illnesses, *****

ii.___ Older adults,

iii.___ Foster care children,

iv._X_ Homeless individuals,*****

v._X_ Individuals with serious and persistent mental illness and/or substance abuse**,***

vi._X_ Non-elderly adults who are disabled or chronically ill with developmental or physical disability, or*****

vii.__ Other (please list):

* **The CHCP does not list special populations but requires Contracting MCOs to meet the special health needs of the enrolled population and to the degree the population is not covered in any other program.**

I. Excluded Populations: The following enrollees will be excluded from participation in the waiver:

1._X_ have Medicare coverage, except for purposes of Medicaid-only services**; (Temporarily Excluded from Enrollment into an MCO). Following a determination from the Pharmacy "carve out" discussions, the CHCP program will determine the feasibility of permitting the voluntary enrollment of this population into a MCO and the appropriate capitation rate to pay MCOs. Any change will be implemented through a contract change with MCOs that will receive prior review by CMS**.

2.___ have medical insurance other than Medicaid;

3._X_ are residing in a nursing facility;

4._X_ are residing in an Intermediate Care Facility for the Mentally Retarded (ICF/MR);

5.___ are enrolled in another Medicaid managed care program;

6.___ have an eligibility period that is less than 3 months;

7.___ are in a poverty level eligibility category for pregnant women;

8.___ are American Indian or Alaskan Native;

9.___ participate in a home and community-based waiver;

10._X_ receive services through the State's Title XXI CHIP program;

11.__ have an eligibility period that is only retroactive;

12._X_ are included under the State's definition of Special Needs Populations. Please ensure that any special populations excluded from the waiver in the eligibility categories in I. above are listed here (Please explain further in Section F. Special Populations if necessary);

i.___ Children with special needs due to physical and/ or mental illnesses,
ii.___ Older adults,
iii._X_ Foster care children,
iv.___ Homeless individuals,
v.___ Individuals with serious and persistent mental illness and/or substance abuse,
vi.___ Non-elderly adults who are disabled or chronically ill with developmental or physical disability, or
vii._X_ Other (please list):

The CHCP does not list special populations but requires Contracting MCOs to meet the special health needs of the enrolled population and to the degree the population is not covered in any other category. **Those children participating in the Children's Waiver are excluded from CHCP enrollment.**

13._X_ have other qualifications which the State may exclude enrollees from participating under the waiver program. Please explain those reasons below:

Spenddown, Childcare institutions, Refugee assistance programs, Repatriate assistance programs, and Residents of county, state, and federal correctional facilities.

m. Automated Data Processing: Federal approval of this waiver request does not obviate the need for the State to comply with the Federal automated data processing systems approval requirements described in 42 CFR Part 433, Subpart C, 45 CFR Part 95, Subpart F, and Part 11 of the State Medicaid Manual.

n. Independent Assessment: The State will arrange for an Independent Assessment of the cost-effectiveness of the waiver and its impact on enrollee access to care of adequate quality. The Independent Assessment is required for at least the first two waiver periods. **This assessment is to be submitted to HCFA at least 3 months prior to the end of the waiver period**. [Please refer to SMM 2111 and HCFA's "Independent Assessment: Guidance to States" for more information]. Please check one of the following:

1. _X_ This is the first or second renewal of the waiver. An Independent Assessment has been completed and submitted to HCFA as required. **See Attachment N, Independent Assessment Report**

2. ___ Independent Assessments have been completed and submitted for the first two waiver periods. The State is requesting that it not be required to arrange for additional Independent Assessments unless HCFA finds reasons to request additional evaluations as a result of this renewal request. In these instances, HCFA will notify the State that an Independent Assessment is needed in the waiver approval letter.

III. PROGRAM IMPACT:

In the following informational sections, please complete the required information to describe your program. The questions should be answered for MCOs and, if applicable, for PHPs.

a. Marketing including indirect MCO/PHP marketing (e.g., radio and TV advertising for the MCO/PHP in general) and direct MCO/PHP marketing (e.g., direct mail to Medicaid beneficiaries). For information to enrollees (i.e., member handbooks), see Section H.

Previous Waiver Period

1. ___ During the last waiver period, the program marketing policies operated differently than described in the waiver governing that period. The differences were:

2. _X_ [Required for all elements checked in the previous waiver submittal] Please describe how often and through what means the State monitored compliance with its marketing requirements [items A.III.a.1-7 of 1999 initial preprint; as applicable in 1995 preprint], as well as results of the monitoring.
The CHCP program has monitored compliance in two different formal ways. The first is through Contract enforcement. The issue of health plan marketing is assessed as part of the CHCP Program's site review of each contracting MCO. This is due to the CHCP Contract with HMOs that specifies that prior approval is necessary before any "permissible" marketing activity is undertaken. It is also

noted in the same section of the Contract of what the prohibited marketing activities and locations were. The second manner of oversight is in providing clarification through official communication. Attachment C to the waiver renewal packet is an example of a letter communicating the CHCP Program's interpretation of marketing issues. The CHCP program also uses the relationship with the State's Enrollment Services Contractor to provide information to Medicaid beneficiaries regarding health plan details that previously may have been provided by individual health plan marketing staff. See Attachment A, Michigan Enrolls Contract for more details on the health plan information provided to beneficiaries. See Attachment B, CHCP Contract with MCOs, Section II-S-1, and Attachment C, CHCP administrative letter, # L-01-17.

Upcoming Waiver Period Please describe the waiver program for the upcoming two-year period. For items 1 through 7 of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response.

1.___ The State does not permit direct or indirect MCO/PHP marketing (go to item "b. Enrollment/Disenrollment")

2._X_ The State permits indirect MCO/PHP marketing (e.g., radio and TV advertising for the MCO/PHP in general). Please list types of indirect marketing permitted. **As noted above, See Attachment B, CHCP Contract with MCOs, Section II-S-1, and Attachment C, CHCP administrative letter, # L-01-17.**

3.___ The State permits direct MCO/PHP marketing (e.g., direct mail to Medicaid beneficiaries). Please list types of direct marketing permitted.

Please describe the State's procedures regarding direct and indirect marketing by answering the following questions and/or referencing contract provisions or Requests for Proposals, if applicable.

4._X_ The State prohibits or limits MCOs/PHPs from offering gifts or other incentives to potential enrollees. Please explain any limitation/prohibition and how the State monitors this**:**

The CHCP Contract states that the MCO may not provide inducements through which compensation, reward, or supplementary benefits or services are offered to Beneficiaries to enroll or to remain enrolled with the MCO. However, the CHCP program has communicate to Contracting MCOs information regarding permissible incentive programs. These programs must be tied to Health Promotion activities or encouragement to adopt

healthy behaviors of current enrolled members. Under these arrangements which have to be prior approved by the CHPC program:

- **<u>Individual incentives</u>: The maximum value of an incentive given to an individual member may not exceed $10.00. Examples of individual-directed incentives include a tee shirt for each newborn or a sport bottle for each member who receives a blood pressure screening.**
- **<u>Limited incentives</u>: The maximum value of an incentive that is given to one of many eligible members is $50.00. An example of a limited incentive is when an HMO conducts a quarterly drawing to award to the member's name drawn at random a gift certificate for up to $50.00 at a local store. In order to be eligible for the drawing, the member must have qualified as defined by the plan, e.g., the member must have received all required immunizations.**

See Attachment B, CHCP Contract with MCOs, Section II-S-2, and Attachment C, CHCP administrative letter # L-01-17.

5.___ The State permits MCO/PHPs to pay their marketing representatives based on the number of new Medicaid enrollees he/she recruited into the plan. Please explain how the State monitors marketing to ensure it is not coercive or fraudulent:

6._X_ The State requires MCO/PHP marketing materials to be translated into the languages listed below (If the State does not translate enrollee materials, please explain): **The CHCP Contract requires that marketing materials be available in languages appropriate to the beneficiaries being served within each county. Further all materials must be culturally appropriate and available in alternative formats in accordance with ADA requirements. See Attachment B, CHCP Contract with MCOs, Section II-S, 3.**

The State has chosen these languages because (check any that apply):

i._X_ The languages comprise all prevalent languages in the MCO/PHP service area.

ii.___ The languages comprise all languages in the MCO/PHP service area spoken by approximately ___ percent or more of the population.

iii.__ Other (please explain):

7._X_ The State requires MCO/PHP marketing materials to be translated into alternative formats for those with visual impairments. **According to the CHCP Contract, marketing materials must be available in languages appropriate to the Beneficiaries being**

served within the county. All material must be culturally appropriate and available in alternative formats in accordance with the Americans for Disabilities Act. **See Attachment B, CHCP Contract with MCOs, Section II-S-3.**

8. ___ **MCO Required Marketing Elements**: Listed below is a description of requirements, which the State must meet under the waiver program (items 1.a through 1.g). These items are optional PHP marketing elements. If an item is not checked, please explain why. The State:

(a) X Ensures that all marketing materials are prior approved by the State Under **the CHCP Contract, the CHCP Program will review and approve any form of marketing. The CHCP Contract also stipulates that only with approval of DCH, may the MCO (HMO) conduct any promotional materials or programs. See Attachment B, CHCP Contract, Section II-S.**

(b) X Ensures that MCO marketing materials do not contain false or misleading information. **The review by the CHCP program of marketing materials is intended to assure that false and misleading information is not permitted. See Attachment B, CHCP Contract, Section II-S.**

(c) X Consults with the Medical Care Advisory Committee (or subcommittee) in the review of MCO marketing materials. **See Attachment C, CHCP administrative letter # L-01-17.**

(d) X Ensures that the MCO distributes marketing materials to its entire service area. **The CHCP Contract requires "that the promotion and distribution of materials is directed at the population of the entire approved service area. See Attachment B, CHCP Contract, Section II-S.**

(e) X Ensures that the MCO does not offer the sale of any other type of insurance product as an enticement to enrollment. **The CHCP Contract prohibits the inducements to beneficiaries of compensation, reward, or supplementary benefits or services as a means to enroll or to remain enrolled with the MCO**. **See Attachment B, CHCP Contract, Section II-S.**

(f) X Ensures that the MCO does not conduct directly or indirectly, door-to-door, telephonic, or other forms of "cold-call"

marketing. **See Attachment B, CHCP Contract with MCOs, Section II-S-2.**

(g) X Ensures that MCO does not discriminate against individuals eligible to be covered under the contract on the basis of health status or need of health services. The CHCP Contract prohibits direct marketing to individual beneficiaries, including door-to-door marketing. **See Attachment B, CHCP Contract, Section II-S-1&2.**

b. Enrollment/Disenrollment:

Previous Waiver Period

1.___ During the last waiver period, the enrollment and disenrollment operated differently than described in the waiver governing that period. The differences were:

[Required for all elements checked in the previous waiver submittal] Please provide a description of how often and through what means the State has monitored compliance with Enrollment/Disenrollment requirements (items A.III.b of the 1999 initial preprint; items A.8, 9, 17(g-j), 20, and 22 of 1995 preprint). Please include the results from those monitoring efforts for the previous waiver period.

The CHCP program has implemented a very detailed monitoring program to assure that enrollment and disenrollment procedures and requirements have been met. Because of the dynamic aspects of provider network contracting, including the addition and deletion of contracted providers, the identification of which provider office is open to new enrollment versus current enrollment, and adherence to specified enrollment capacity levels in each county, the CHCP program has established a procedure to review enrollment issues daily, weekly, bi-weekly and monthly. In each of those timeframes, a determination can be made to either open or close enrollment based on provider adequacy. The conduct of this assessment is made in tandem with the Enrollment Services Contractor, (MICHIGAN ENROLLS). The Report generated by MICHIGAN ENROLLS (Attachment M) list each health plan by approved county along with the enrollment capacity, available PCPs and remaining capacity for each Plan. This report, updated bi-weekly, provides the objective data necessary to render decisions regarding health plan enrollment status in each of Michigan's 83 counties.

The lead responsibility for enrollment activities (delegated to MICHIGAN ENROLLS) has been separated from disenrollment activities, which are retained by the Department of Community Health. DCH staff is provided with each individual request for

disenrollment. Under the CHCP Contract there are three types of disenrollment requests that may be initiated by the MCO:

- **Violent/life threatening situations involving physical acts of violence; physical or verbal threats of violence made against MCO providers, staff or the public at MCO locations; or stalking situations. In each of these instances a police record must be attached to the request;**
- **Fraud/misrepresentation involving alteration or theft of prescriptions, misrepresentation of MCO membership, or unauthorized use of CHCP benefits; and**
- **Other noncompliance situations involving the failure to follow treatment plan; repeated use of non-MCO providers;**
- **MCO provider refusal to see the enrollee; repeated use of emergency room, and other situations that impede care.**

The MCO may also initiate disenrollment if the beneficiary becomes medically eligible for services under Title V or is admitted to a nursing facility for custodial care. Under both of these instances, Medicaid services are provided under different arrangements following disenrollment.

Beneficiaries may seek medical exceptions to managed care as described in the CHCP Contract, (Section II-G-12). They may also seek disenrollment for cause at any time. Reasons cited may include poor quality of care or lack of access. (Section II-G-13 of CHCP Contract). See Attachment B, CHCP Contract, Section II-E (Enrollment) and Attachment M (Enrollment Capacity Reports).

Upcoming Waiver Period - Please describe the State's enrollment process for MCOs/PHPs by checking the applicable items below. For items 1 through 6 of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response.

1. _X_ **Outreach:** The State conducts outreach to inform potential enrollees, providers, and other interested parties of the managed care program (e.g., media campaigns, subcontracting with community-based organizations or out stationed eligibility workers). Please describe the outreach process, and specify any special efforts made to reach and provide information to special populations included in the waiver program: **Outreach to inform potential enrollees, providers, and other interested parties of the managed care program is conducted by the enrollment services broker through educational sessions. Posters are provided to community agencies and sample enrollment packets for agencies to build awareness with its potential enrollees. The toll-free number is known in the community,**

and printed on the posters, publications, and community update communications. The Michigan ENROLLS Call Center continues to provide enrollment assistance and managed care education.

2.___ **Administration of Enrollment Process**:

(a)__ State staff conduct the enrollment process.

(b)_X_ The State contracts with an independent contractor(s) (i.e., enrollment broker) to conduct the enrollment process and related activities. The State must request a waiver of 1915(b)(2) in Section A.II.g.1. (Refer to Section 2105 of the State Medicaid Manual)

i. Broker name: **Maximus, Inc. (DBA Michigan Enrolls)**
ii. Procurement method: **Competitive**
iii. Please list the functions that the contractor will perform:

-MC enrollments
-MC disenrollments
-Mail out brochures, information guide, and other information
-Medicaid help line
-Title V help line (CSHCS)
-CSHCS enrollments
-Contract with commercial organizations for outreach & education
-Maintain provider files for HMOs

(c)__ State allows MCOs/PHPs to enroll beneficiaries. Please describe the process and the State's monitoring.

3. **Enrollment Requirement:** Enrollment in the program is:

(a)_X_ Mandatory for populations in Section A.II.I

(b)_X_ Voluntary -- See Cost-effectiveness Section D introduction for instructions on inclusion of costs and enrollment numbers (please describe populations for whom it will be voluntary):
Voluntary populations are described in the CHCP Contract, Section II-E-2 and currently include the following:

- **Migrant population**
- **Native Americans**
- **Persons in the Traumatic Brain Injury Program**

- **Pregnant Women, who pregnancy is the basis for Medicaid eligibility; and**
- **Pregnant Women who are in their third trimester of pregnancy**

It is anticipated during the upcoming waiver period that the voluntary status will also be provided to persons with both Medicaid and Medicare eligibility who are currently listed as an excluded population. CMS will be notified in advance of such change as that change will be made through a contract change notice.

(c)___ Other (please describe):

4. **Enrollment:**

(a)_X_ The State will make counseling regarding their MCO/PHP choices prior to the selection of their plan available to potential enrollees. Please describe location and accessibility of sites for face-to-face meetings and availability of telephone access to enrollment selection counseling staff, the counseling process, and information provided to potential enrollees. **Enrollment Counseling will be provided by MICHIGAN ENROLLS through telephone access, face to face meetings and via information distributed in the mail. MICHIGAN ENROLLS holds subcontracts with local agencies that provide both information sessions as well as opportunities for individual counseling. The majority of enrollment contact is through the telephone as noted in the Monthly enrollment statistics (See Also Attachment D, Enrollment Packets).**

The CHCP Contract requires each of the MCOs to provide to the Enrollment Services Contractor provider files. These provider files contain a complete description of the provider network available to enrollees, (Section II-M-6-a). This section further requires the files to be provided in a format specified by the MDCH, updated as necessary to reflect changes in the network, and submitted to MICHIGAN ENROLLS in a timely manner. Further, (as noted in Attachment I, Performance Standards), the CHCP program has developed a contractual performance standard regarding the timely and completeness of submission of provider files. This is an important fact as the information provided to beneficiaries is based largely on

the information provided under this requirement. See also, Attachment D, (Enrollment Packet)

(b) _X_ Enrollment selection counselors will have information and training to assist special populations and persons with special health care needs in selecting appropriate MCO/PHPs and providers based on their medical needs. Please describe. **All counselors hired by Maximus, (dba MICHIGAN ENROLLS) are given initial training that addresses the special needs of the Medicaid population, such as referral to community mental health agencies and other local agencies that provide services for that population. They also have desk references that will provide the information in writing that can be referred to after training is completed. The MICHIGAN ENROLLS maintains a dedicated TTY phone line for hearing impaired. The field staff is also provided with the same training as the call center staff. The regional coordinators, who oversee the field staff, are also available to provide assistance for beneficiaries and their families in accessing necessary services, coordinating with local agencies and in assuring such services are available within the MCO choices for new enrollees.**

(c) _X_ Enrollees will notify the State/enrollment broker of their choice of plan by:
i. _X_ mail
ii. _X_ phone
iii. _X_ in person at **MI Enrolls Field Office**
iv. ___ other (please describe):

(d) _X_ [Required for MCOs and PHPs] There will be an open enrollment period during which the plans will accept individuals who are eligible to enroll. Please describe how long the open enrollment period is and how often beneficiaries are offered open enrollment. Please note if the open enrollment period is continuous (i.e., there is no enrollment lock-in period).
All beneficiaries enrolled in Medicaid MCOs are notified more than 60 days prior to the end of the 12-month lock in period regarding their ability to make alternative choices during "open enrollment". Open enrollment letters are distributed in time for beneficiaries to contact the enrollment broker, Michigan Enrolls, during the period May 1-31 of each year. The effective date of open

enrollment changes is July 1st of each year. Subsequently, any beneficiary who chose an alternative MCO will have an additional 90 days after July 1st in the event he or she would wish to make another change. This is described in Section II-G-3 of the CHCP Contract.

(e) X Newly eligible beneficiaries will receive initial notification of the requirement to enroll into the program. Please describe the initial notification process.
As described in Section II-G-2 of the CHCP Contract, beneficiaries will receive a packet of information by mail.

(f)___ Mass enrollments are expected. Please describe the initial enrollment time frames or phase-in requirements:

(g) X If an enrollee does not select a plan within the given time frame, the enrollee will be auto-assigned or default assigned to a plan.

i. Potential enrollees will have 3 days/month(s) to choose a plan.
ii. Please describe the auto-assignment process and/or algorithm. What factors are considered? Does the auto-assignment process assign persons with special health care needs to an MCO/PHP that includes their current provider or to an MCO/PHP that is capable of serving their particular needs? **New Medicaid Beneficiaries are provided with information from MICHIGAN ENROLLS as outlined below:**

- **New member packets are sent out to new members**
- **In 17 days a reminder notice is sent to new members if they have not responded to packet**
- **In 17 days, a new member is auto-assigned to HMO, if no response is received. They are assigned to a comprehensive MCO, which, by definition, can suit their needs.**
- **The automatic enrollment algorithm combines clinical performance factors, (well-child visits, immunization rates, and timeliness of monthly prenatal care) with administrative factors, (timeliness of monthly claims reporting and encounter data reporting). Clinical factors are weighted 2/3 and administrative factors weighted**

1/3 during this phase of the algorithm. The score is then weighted again by the competitive bid score to arrive at the final algorithm value.

(h) __ The State provides guaranteed eligibility of ____ months for all managed care enrollees under the State plan. How and at which point(s) in time are potential enrollees notified of this?

(i) X The State allows otherwise mandated beneficiaries to request exemption from enrollment in an MCO/PHP. Please describe the circumstances under which an enrollee would be eligible for exemption from enrollment. In addition, please describe the exemption process: **A beneficiary may request an exception to enrollment in the CHCP if he or she has a serious medical condition and is undergoing active treatment for that condition with a physician that does not participate with the MCO at the time of the enrollment. The Beneficiary would request this information of the MDCH or MICHIGAN ENROLLS staff and complete and return an exemption form. MDCH will respond to the request and if granted, the beneficiary will be exempted for up to 12 months. See Attachment B, CHCP Contract, II-G-12, Medical Exception.**

5. **Disenrollment:**

(a) X The State allows enrollees to disenroll/transfer between MCOs/PHPs. Please explain the procedures for disenrollment/transfer:
Enrollee can transfer during open enrollment.
See Attachment E, Procedures for Disenrolling Members Due to Change in Service Area and Attachment B, CHCP Contract, Section II-G-11.

(b) __ The State does not allow enrollees to disenroll from the PHP.

(c) X The State monitors and tracks disenrollments and transfers between MCOs/PHPs. Please describe the tracking and analysis:
First, the MDCH and MICHIGAN ENROLLS are involved in the determination and approvals of disenrollments. For transfers between health plans, agreements must be in place to honor continuity of care issues, prior

authorizations for DME and prescriptions. The CHCP program also reviews the tracking through the enrollment capacity reports produced by MICHIGAN ENROLLS and the monthly enrollment reports. This provides data to assure that current capacity is still available and providers are still open to enrollment. Finally, all actions related to beneficiaries are recorded in the Beneficiary-tracking program, BPCT. Therefore, any beneficiary complaint or contact will be recorded in the electronic system and reviewed with health plans.

(d) _X_ The State has a lock-in period of _12_ months (up to 12 months permitted). If so, the following are required:

i. _X_ MCO enrollees must be permitted to disenroll without cause within the first 90 days of each enrollment period with each MCO.

ii ___ PHP enrollees must be permitted to disenroll without cause within the first month of each enrollment period with each PHP.

iii. _X_ MCO enrollees must be notified of their ability to disenroll or change MCOs at the end of their enrollment period at least 60 days before the end of that period.

iv. _X_ MCO and PHP enrollees have the following good cause reasons for disenrollment are allowed during the lock-in period:
Under the CHCP Contract, (See Attachment B, II-G-13), an enrollee may request a disenrollment for cause from a MCO at any time during the enrollment period. Reasons cited in a request may include poor quality care or lack of access to necessary specialty services. If granted disenrollment, the beneficiary will be required to enroll into a different MCO.

(e)__ The State does not have a lock-in, and enrollees in MCOs/PHPs are allowed to terminate or change their enrollment without cause at any time. Please describe the effective date of an enrollee disenrollment request.

6. **MCO/PHP Disenrollment of Enrollees**: If the State permits MCOs/PHPs to request disenrollment of enrollees, please check items below, which apply:

(a) _X_ The MCO/PHP can request to disenroll or transfer enrollment of an enrollee to another plan. If so, it is important

that reasons for reassignment are not discriminatory in any way -- including adverse change in an enrollee's health status and non-compliant behavior for individuals with mental health and substance abuse diagnoses -- against the enrollee. Please describe the reasons for which the MCO/PHP can request reassignment of an enrollee:
As stated in the CHCP Contract (see Attachment B, II-G-11), the MCO may initiate special disenrollment request to MDCH under the following general categories:

- **Violent/life threatening situations involving physical acts of violence; physical or verbal threats of violence made against MCO providers, staff, or public at MCO locations or stalking situations;**
- **Fraud/misrepresentation involving alterations or theft of prescriptions, misrepresentation of MCO membership, or unauthorized use of plan benefits; and**
- **Non-compliant situations involving the failure to follow treatment plans, repeated use of non-MCO providers, etc.**

(b) X The State reviews and approves all MCO/PHP-initiated requests for enrollee transfers or disenrollments.

(c) X If the reassignment is approved, the State notifies the enrollee in a direct and timely manner of the desire of the MCO/PHP to remove the enrollee from its membership.

(d) X The enrollee remains a member of the MCO/PHP until another MCO/PHP is chosen or assigned.

C. Entity Type or Specific Waiver Requirements

Previous Waiver Period

1.___ During the last waiver period, the program operated differently than described in the waiver governing that period. The differences were:

Upcoming Waiver Period -- Please describe the entity type or specific waiver requirements for the upcoming two-year period. For items 1 through 4 of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response.

1. _X_ **Required MCO/PHP Elements:** MCOs/PHPs will be required to comply with all applicable federal statutory and regulatory requirements, including those in Section 1903(m) and 1932 of the Act, and 42 CFR 434 et seq.

2. _X_ **Required Elements Relating to Waiver under Section 1915(b)(4):** If the State is requesting a waiver under Section 1915(b)(4) of the Social Security Act, please mark the items that the State is in compliance with:

   (a) _X_ The State believes that the requirements of section 1915(b)(4) of the Act are met for the following reasons:

      i. _X_ Although the organization of the service delivery and payment mechanism for that service are different from the current system, the standards for access and quality of services are the same or more rigorous than those in your State's Medicaid State Plan.

      ii. _X_ MCO/PHP must provide or arrange to provide for the full range of Medicaid services to be provided under the waiver.

      iii. _X_ MCO/PHP must agree to accept as payment the reimbursement rate set by the State as payment in full.

      iv. _X_ Per 42 CFR 431.55(f)(2)(i), enrollees residing at a long term care facility are not subject to a restriction of freedom of choice based on this waiver authority unless the State arranges for reasonable and adequate enrollee transfer.

      v. _X_ There are no restrictions that discriminate among classes of providers on ground unrelated to their demonstrated effectiveness and efficiency in providing services.

3. The State has/will select the MCOs/PHPs that will operate under the waiver in the following manner:

   (a) _X_ The State has used/will use a competitive procurement process. Please describe.
   Michigan has used the competitive procurement process administered by the State's Office of

Purchasing. Under this process, the MDCH develops a Request for Proposal that is reviewed by the State Purchasing Director and Attorney General Staff assigned to that office. Distribution and the selection process are facilitated by the State Purchasing Director. All procurement information, including written materials, question/answer documents and public meetings are conducted by the Office of Purchasing. The Office of Purchasing will make all final procurement decisions and administered appeals that may result from their decisions. Upon final selection, the Contracts are then forwarded to the MDCH for the day-to-day administration. Any contract change will be formally administered by the Purchasing Director. Michigan has conducted three competitive bids under the Waiver, the most recent taking place during calendar year 2000 with approved Contracts effective October 1, 2000. That contract was a maximum five-year contract, with the final three years as optional extensions. A copy of the current CHCP Contract is included as attachment B. The Office of Purchasing has recently issued Contract Change Notices to all Contracting HMOs implementing extension of the CHCP Contract through September 30, 2004. All of these Contract changes have been filed with CMS, including the recent extension of the terms of the Contract.

(b)__ The State has used/will use an open cooperative procurement process in which any qualifying MCO/PHP may participate that complies with federal procurement requirements and 45 CFR Section 74.

(c)__ The State has not used a competitive or open procurement process. Please explain how the State's selection process is consistent with federal procurement regulations, including 45 CFR Section 74.43 which requires States to conduct all procurement transactions in a manner to provide to the maximum extent practical, open and free competition.

4 _X_ Per Section 1932(d) of the Act, the State has conflict of interest safeguards with respect to its officers and employees who have responsibilities related to MCO contracts and the default enrollment process now established for MCOs.

d. SERVICES

Previous Waiver Period

1.___ During the last waiver period, the program operated differently than described in the waiver governing that period. The differences were:

2._X_ [Required for all elements checked in the previous waiver submittal] Please provide a description of how often and through what means the State has monitored compliance with service provision requirements. [items A.III.d.2-6 of the 1999 initial preprint; items A.13, 14, 21 of the 1995 preprint]. Please include the results from those monitoring efforts for the previous waiver period.
Similar to the response to other questions, the monitoring is handled in multiple ways, the most prominent is the on-site reviews under taken by the Comprehensive Health Plan Division staff (Contract managers and Quality Improvement analysts). See Attachment J, Site Visit Survey Tool and Attachment Q, Onsite Summary Report. The Independent Assessment (already forwarded to CMS) but which is included as Attachment N summarizes the results from the State's monitoring of services.

The CHCP Program also measures compliance through other formal and informal means. This includes the use of HEDIS, EQR and other reports such as the assessment of the encounter data and other utilization information, and the review of complaint and grievance reports.

Upcoming Waiver Period -- Please describe the service-related requirements for the upcoming two year period. For items 1 through 7 of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response.

1. The Medicaid services MCO/PHPs will be responsible for delivering, prescribing, or referring to are listed in the chart below. The purpose of the chart is to show which of the services in the State's state plan are/are not in the MCO/PHP contract; which non-covered services are impacted by the MCO/PHP (i.e. for calculating cost effectiveness; see Appendix D.III); and which new services are available only through the MCO/PHP under a 1915(b)(3) waiver. When filling out the chart, please do the following:

(Column 1 Explanation) Services: The list of services below is provided as *an example only. States should modify the list to include:*

-- all services available in the State's State Plan, regardless of whether they will be included or excluded under the waiver

-- subset(s) of state plan amendment services which will be carved out, if applicable; for example, list mental health separately if it will be carved out of physician and hospital services
-- services not covered by the state plan (note: only add these to the list if this is a 1915(b)(3) waiver, which uses cost savings to provide additional services)

(Column 2 Explanation) State Plan Approved: Check this column if this is a Medicaid State Plan approved service. This information is needed because only Medicaid State Plan approved services can be included in cost effectiveness. For 1915(b)(3) waivers it will also distinguish existing Medicaid versus new services available under the waiver.

(Column 3 Explanation) 1915(b)(3) waiver services: If a covered service is not a Medicaid State Plan approved service, check this column. Marking this column will distinguish new services available under the waiver versus existing Medicaid service.

(Column 4 Explanation) MCO/PHP Capitated Reimbursement: Check this column if this service will be included in the capitation or other reimbursement to the MCO/PHP. All services checked in this column should be marked in Appendix D.III in the "Capitated Reimbursement" column.

(Column 5 Explanation) Fee-for-Service Reimbursement: Check this column if this service will NOT be the responsibility of the MCO/PHP, i.e. not included in the reimbursement paid to the MCO/PHP. However, do not include services impacted by the MCO/PHP (see column 6).

(Column 6 Explanation) Fee-for-Service Reimbursement impacted by MCO/PHP: Check this column if the service is not the responsibility of the MCO/PHP, but is impacted by it. For example, if the MCO/PHP is responsible for physician services but the State pays for pharmacy on a FFS basis, the MCO/PHP will impact pharmacy use because access to drugs requires a physician prescription. All services checked in this column should appear in Appendix D.III (in "Fee-For-Service Reimbursement" column). Do not include services NOT impacted by the MCO/PHP (see column 5).

Service (1)	State Plan Approved (2)	1915(b)(3) waiver services (3)	MCO/PHP Capitated Reimburse-ment (4)	Fee-for-Service Reimburse-ment (5)	Fee-for-Service Reimbursement impacted by MCO/PHP (6)
Day Treatment Services (mental					X

Service (1)	State Plan Approved (2)	1915(b)(3) waiver services (3)	MCO/PHP Capitated Reimburse-ment (4)	Fee-for-Service Reimburse-ment (5)	Fee-for-Service Reimbursement impacted by MCO/PHP (6)
health)					
Dental	X			X	X
Detoxification	X				X
Developmental Disabilities Services (pharmacy and related services)	X			X	X
Durable Medical Equipment	X		X		
Emergency Services (ambulance)	X		X		
EPSDT and well-child	X		X		
Family Planning Services	X		X		
Federally Qualified Health Center Services	X		X		
Health Education and Promotion	X		X		
Home Health	X		X		
Home and Community based program services	X				
Hospice	X		X		
Immunizations	X		X		
Inpatient Hospital - Psych					X
Inpatient Hospital - Other	X		X		
Laboratory and Xray Services	X		X		
Mental Health Services (up to 20	X		X		

Service (1)	State Plan Approved (2)	1915(b)(3) waiver services (3)	MCO/PHP Capitated Reimburse-ment (4)	Fee-for-Service Reimburse-ment (5)	Fee-for-Service Reimbursement impacted by MCO/PHP (6)
visits per year)					
Mental Health Services (over 20 visits per year)	X				X
Nurse midwife	X		X		
Nurse practitioner	X		X		
Nursing Facility	X				X
Obstetrical services	X		X		
Occupational therapy	X		X		
Other Outpatient Services – Chiropractor, podiatrist	X		X		
Psych Practitioner (Mental Health)	X				X
Outpatient Hospital - Lab & X-ray, all other	X		X		
Outreach (Pregnancy and well-child)	X		X		
Parenting and Birthing Classes	X		X		
Partial Hospitalization (Mental Health)	X				X
Personal Care	X				X
Pharmacy	X		X		X
Physical Therapy	X		X		
Physician	X		X		
Private duty nursing (see bulletin MSA02-03)	X	X			X

Service (1)	State Plan Approved (2)	1915(b)(3) waiver services (3)	MCO/PHP Capitated Reimburse-ment (4)	Fee-for-Service Reimburse-ment (5)	Fee-for-Service Reimbursement impacted by MCO/PHP (6)
Prosthetics and Orthotics	X		X		
Psychological testing	X		X		
Psychologist (CMH)	X				X
Rehabilitation Treatment Services	X		X		
Renal Disease (end stage services)	X		X		
Respiratory care	X		X		
Rural Health Clinic	X		X		
School Based Services	X		X		
Speech Therapy	X		X		
Substance Abuse Treatment Services	X				X
Testing and treatment for sexually transmitted diseases (STDs)	X		X		
Transplant Services	X		X		
Transportation - Emergency	X		X		
Transportation - Non-emergency	X		X		
Transportation for non-covered services		X			
Vision Exams and Glasses	X		X		
Weight Reduction	X		X		

2. **Emergency Services (Required)**. The State must ensure enrollees in MCOs/PHPs have access to emergency services without prior authorization even if the emergency provider does not have a contractual relationship with the entity. For PHPs, "emergency services" means covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish such services, and are needed to evaluate or stabilize an emergency medical condition.

For MCOs, "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.

(a)__ The State has a more stringent definition of emergency medical condition for MCOs or PHPs than the definition above. Please describe.

The State takes the following required steps to ensure access to emergency services. If an item below is not checked, please explain.

(b)_X_ The State ensures enrollee access to emergency services by requiring the MCO/PHP to provide adequate information to all enrollees regarding emergency service access. **The CHCP Contract requires each MCO to include information in the member handbook regarding what to do in case of an emergency and instructions for receiving advice on getting care in case of any emergency. This would include accessing 9-1-1, and obtaining emergency transportation.(see Attachment B, CHCP Contract, Section II-T, (Member and Enrollee Services)**

(c)_X_ The State ensures enrollee access to emergency services by including in the contract requirements for MCOs/PHPs to cover the following. Please note that this requirement for coverage does not stipulate how, or if, payment will be made. States may give MCOs/PHPs the flexibility to develop their own payment mechanisms, e.g. separate fee for screen/evaluation and stabilization, bundled payment for

both, etc. **The CHCP program covers the categories of emergency services as noted below. Under the CHCP Contract, MCOs must cover emergency services, (which are defined using the "prudent layperson" definition in the Contract), as well as medical screening exams consistent with the Emergency Medical Treatment and Active Labor Act, EMTALA. Further the CHCP Contract assures that this service is to be provided without prior authorization. (See Attachment B, CHCP Contract, Section II-I-1). This was further clarified in a Medical Policy Bulletin promulgated by the MDCH for services provided by Hospitals for managed care enrolled members, (Attachment P, Hospital Access Agreement).**

i. _X_ For the screen/evaluation and all medically necessary emergency services when an enrollee is referred by the PCP or other plan representative to the emergency room, regardless of whether the prudent layperson definition was met,

ii. _X_ The screen/evaluation, when an absence of clinical emergency is determined, but the enrollee's presenting symptoms met the prudent layperson definition,

iii. _X_ Both the screening/evaluation and stabilization services when a clinical emergency is determined,

iv. _X_ Continued emergency services until the enrollee can be safely discharged or transferred,

v. _X_ Post-stabilization services which are pre-authorized by the MCO/PHP, or were not pre-authorized, but the MCO/PHP failed to respond to request for pre-authorization within one hour, or could not be contacted (Medicare+Choice guideline). Post-stabilization services remain covered until the MCO/PHP contacts the emergency room and takes responsibility for the enrollee.

3. **Family Planning**: In accordance with 42 CFR 431.51(b), preauthorization by the enrollee's PCP (or other MCO/PHP staff), or requiring the use of participating providers for family planning services is prohibited under the waiver program. **Family Planning arrangements under the waiver are noted below. The CHCP Contract requires MCOs to permit their enrolled members to**

have full freedom of choice of family planning providers—both in plan and out-of-network. Further, the Contract requires the MCO to pay providers of family planning services who do not have contractual relationships at the established Medicaid fee-for-service fee administered by the MDCH for participating Medicaid providers. The Contract also requires the MCO to include in the member handbook information regarding how to access family planning service. (See Attachment B, CHCP Contract, Section II-I-3 (Family Planning) and Section II-T, Member and Enrollee Services).

(a)_X_Enrollees are informed that family planning services will not be restricted under the waiver.

(b)_X_Non-network family planning services are reimbursed in the following manner:

i._X_ The MCO/PHP will be required to reimburse non-network family planning services

ii.___ The MCO/PHP will be required to pay for family planning services from network providers, and the State will pay for family planning services from non-network providers

iii.___The State will pay for all family planning services, whether provided by network or non-network providers

iv.___ The State pays for non-network services and capitated rates were set accordingly.

v.___ Other (please explain):

(c) __ Family planning services are not included under the waiver.

4._X_ **Other Services to Which Enrollee Can Self-Refer**: In addition to emergency care and family planning, the State requires MCOs/PHPs to allow enrollees to self-refer (i.e. access without prior authorization) to the following services (Please note whether self-referral is allowed only to network providers or to non-network providers):
Under the CHCP Contract, Medicaid beneficiaries may seek the following covered services without prior authorization:

- **Immunization and communicable disease management from local Public Health Departments regardless of network**

affiliation, (See Attachment B, CHCP Contract, Sections II-I-10 and II-I-14.),

- **Routine OB/GYN and pediatric services from network providers;) See Attachment B, CHCP Contract, Section II-T-3)**
- **School Based/School Linked (Adolescent) Health Centers regardless of network affiliation. (See Attachment B, CHCP Contract, Section II-I-16).**

5. _X_ **Monitoring Self-Referral Services**. The State places the following requirements on the MCO/PHP to track, coordinate, and monitor services to which an enrollee can self-refer: **The CHCP program requires the MCO to submit encounter data for all utilization (network and out-of-network services). Further, under licensing requirements, different reserve requirements are necessary if total payments for out-of-network providers exceeds 10% of the total payouts. Finally, the Contract does require the out-of-network provider to submit data necessary for MCO reporting purposes.**

6. _X_ **Federally Qualified Health Center** (FQHC) Services will be made available to enrollees under the waiver in the following manner (indicate one of the following, and if the State's methodology differs, please explain in detail below):

(a)__ The program is **voluntary**, and the enrollee can disenroll at any time if he or she desires access to FQHC services. No FQHC services will be required to be furnished by the MCO/PHP to the enrollee during the enrollment period.

(b)_X_ The program is **mandatory** and the enrollee is guaranteed a choice of at least one MCO/PHP, which has at least one FQHC as a participating provider. If the enrollee elects not to select the MCO/PHP that gives him or her access to FQHC services, no FQHC services will be required to be furnished to the enrollee while the enrollee is enrolled with the MCO/PHP he or she selected. In any event, since reasonable access to FQHC services will be available under the waiver program, FQHC services outside the program will not be available. Please explain how the State will guarantee all enrollees will have a choice of at least one MCO/PHP with a participating FQHC:
The CHCP Contract requires MCOs to provide enrollees with access to services provided through a FQHC if the Enrollee resides in the FQHC service area and if the Enrollee requests such service. For purposes of this

requirement, the service area is defined as the county in which the FQHC is located. FQHC services must be prior authorized by the MCO, however the MCO may not refuse to authorize medically necessary services if the MCO does not have a FQHC in the network for the service area (County) and an FQHC is available in the county. Because FQHC are not available in all 83 counties of Michigan, the guarantee to access to FQHC can only be provided for enrollees who reside in the county where an FQHC is available. See Attachment B, CHCP Contract II-I-5,.

(c)__ The program is **mandatory** and the enrollee has the right to obtain FQHC services **outside** this waiver program through the regular Medicaid Program.

7. **EPSDT Services:** The State has coordinated and monitored EPSDT services under the waiver program as follows: **As is the case for all covered services under the CHCP Contract, the performance of individual health plans are monitored in several ways. The discussion below indicates the data requirements. The CHCP program also monitors this provision through the on-site reviews. See Attachment F, Michigan Comp Plan On-Site Review Report, Section VI.**

(a) X The State requires MCOs/PHPs to report EPSDT screening data, including behavioral health data (e.g., detailed health and development history including physical and mental health assessments). Please describe the type and frequency of data required by the State.
Michigan requires Contracting MCOs to report EPSDT data on monthly encounter data reports. The implementation of performance standards, including standards for EPSDT, relies on encounter data. Additionally, the reporting to CMS of the EPSDT on the 416 reports is now generated through the use of encounter data. Attachment G is the 416 Report and Attachment I is the Contract Performance Standards, which include well-child visits.

(b) _X_ EPSDT screens are covered under this waiver. Please list the State's EPSDT annual screening rates, including behavioral components, for previous waiver period. (Please note*: HCFA requested that each State obtain a baseline of EPSDT and immunization data in the initial application. That baseline could have been the data

reported in the HCFA 416 report or it may be rates/measures more specific to the Medicaid managed care population. Those rates from the previous submission should be compared to the current rates and the reports listed here.) Please describe whether screening rates increased or decreased in the previous waiver period and which activities the State will undertake to improve the percentage of screens administered for enrollees under the waiver. **Both the Michigan Independent Assessment Report, (Attachment N) and the Michigan Comp Plan On-site Review Report (Attachment F) provide extensive coverage on this issue. It was acknowledged that while slight improvement has occurred over the waiver period, further improvement is expected.**

Michigan HCFA 416 Participation Rates for 1997-2000

Year	Participation Rate for All Children
1997	35%
1998	45%
1999	40%
2000	43%

As noted in the CMS site visit report, Michigan's participation rates are better for infants and younger children, but progressively decline for older age groups. For fiscal year 2000, a 72% participation rate for children under one year was reported.

The following table displays the weighted aggregate rates by age of all MCOs in the 1999 EQR:

	Age 0-2	Age 3-6	Age 7-12	Age 13-21
Initial /Interval History	76%	68%	58%	59%
Physical Examinations	70%	60%	45%	39%
Immunization Review	85%	71%	48%	36%
Anticipatory Guidance	55%	41%	27%	25%

(c) _X_ Immunizations are covered under this waiver. Please list the State's immunization rates for previous waiver period. What activities will the State initiate to improve immunization rates for enrollees under the waiver?

The State has initiated the following activities to improve immunization rates for enrollees under the waiver:

1. **Participation in the GPRA project**
2. **Development and implementation of immunization performance standards (See Attachment I, Performance Standards).**
3. **Requirement for plans not meeting standard to participate in immunization project and develop improvement plans (See attachment H, Wayne County Immunization Project Summary).**
4. **Coordination of activity for MCIR enhancements (development of web based access).**

(d) _X_ Managed care providers are required to enroll in the Vaccines for Children Program. If not, please explain.

(e) _X_ Mechanisms are in place to coordinate school services with those provided by the MCO/PHP. Please describe and clarify the aspects of school services that are coordinated including IEPS, IFSPs, special education requirements, and school-based or school-linked health centers (e.g., plan requirements for PCP cooperation or involvement in the development of the IEPs).

The Contract recommends the coordination of services with a variety of community based organizations that may be available in each of the MCOs service area, (See Attachment B, II-M-6-c). This would include agencies providing services for adolescents. Through a recent contract change, the MCOs are now able to contract and designate school based/school linked health clinics as a PCP, if the center meets minimum credentialing criteria. Further, the CHCP Contract permits enrollees to obtain services from a School Based/School linked Health Center (SBLHC) without prior authorization from the MCO. The MCO would be responsible for payment to the SBLHC at Medicaid Fee-for-service rates in effect on the date of service. (See Attachment B, CHCP Contract, Section II-I-16).

(f) _X_ Mechanisms are in place to coordinate other aspects of EPSDT (e.g., dental, mental, Title V, etc) with those provided by the MCO/PHP. Please describe.

Under terms of the CHCP Contract, MCOs must provide appropriate referral services for each child that receives EPSDT services, even if the service (such as dental) is not a benefit covered under the MCO contract, (See Attachment B, II-I-9). Further, each MCO and Community Mental Health Service Program, CMHSP, are required to establish and implement local coordination agreements to assure that coordination of care is facilitated. Finally, coordination with Title V program is most often demonstrated by the case finding performed by MCOs who provide initial screening of children and determine that they likely qualify for Michigan's Children's Special Health Care Services, CSHCS, Program. Annually, over 2,000 children, enrolled with MCOs have been identified and subsequently enrolled in the CSHCS program. Provisions for this transfer are outlined both in the Contract (see Attachment B, CHCP Contract, Section II-U-4-b&c) and in an Administrative letter (see Attachment V).

Section B. Access and Capacity

A Section 1915(b) waiver program serves to improve an enrollee's access to quality medical services. A waiver must assure that services provided are of adequate amount, are provided within reasonable time frames, and are furnished within a reasonable distance from the residence of the enrollees in the program. Furthermore, the proposed waiver program must not substantially impair access to services and access to emergency and family planning services must not be restricted.

I. Access Standards

Previous Waiver Period

a.___ During the last waiver period, the access standards of the program were operated differently than described in the waiver governing that period. The differences were:

Upcoming Waiver Period -- For items a. through c. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Please describe the State's availability standards for the upcoming waiver period.

a. X **Availability Standards**: The State has established maximum distance and/or travel time requirements, given clients normal means of transportation, for MCO/PHP enrollees' access to the following. Check any that apply (1-9). For each item checked, please describe the standard and answer monitoring questions 10, 11 and 12.

1. X PCPs (please describe your standard): As **described in the CHCP Contract, (Attachment B, CHCP Contract, Section II-M-6-a), Primary care providers must be available to enrollees within 30 minutes or 30 miles. Exceptions to this standard may be granted if the MCO documents that no other network or out-of-network provider is accessible within the 30 minutes and 30 miles standard. Exceptions are also permitted when the enrollee chooses otherwise, (Attachment B CHCP Contract, Section II-M-6-l).**

2. X Specialists (please describe your standard): **The CHCP Program does not have a specific standard for specialist. However, the CHCP Contract does require the MCO to provide reasonable access depending on the type of specialist or subspecialist, (CHCP Contract, Section II-M-6-a). Further the Contract holds the MCO responsible for providing access to all appropriate providers, including qualified specialists for all medically necessary services, (CHCP Contract, Section II-B-3). The MCO**

is required to submit provider files to the State's Enrollment Services Contractor, MICHIGAN ENROLLS, that provides a description of the MCO's service network, including the specialty and hospital network and arrangements for provision of medically necessary non-contracted specialty care. The initial approval of a service area is the responsibility of the State Office of Financial and Insurance Services, OFIS. That review and approval is predicated on a demonstration that adequate capacity is available through both contracted and out-of-network arrangements. The CHCP program accepts the determination by OFIS and subsequently monitors network adequacy to assure that any changes in the network arrangements do not affect the ability of a beneficiary to obtain needed care.

The MCO is required to implement a Quality Assessment and Performance Improvement Program, (CHCP Contract, Section II-P-1). Within this assessment, the MCO is expected to establish and implement their own access standards in such areas as appointment times for PCPs and Specialist. The CHCP program assesses the performance of the MCO in implementing their standards. Finally, the annual Consumer survey, required under the Contract, (CHPC Contract Section II-P-5) includes beneficiary responses regarding access to care, including that of specialist.

3. _X_ Ancillary providers (please describe your standard): **As Described above**.

4. _X_ Pharmacies (please describe your standard): **As described in the CHCP Contract, it is the expectation that the MCOs will assure access within 30 minutes travel time and that the services will be available during evenings and weekends also, (Attachment B, CHCP Contract, Section II-M-6-a). Also the annual consumer satisfaction survey includes questions related to pharmacy.**

5. _X_ Hospitals (please describe your standard): For **Contracted hospital providers, MCOs, must assure that access is available to enrollees within 30 minutes or 30 miles. Exceptions to this standard may be granted if the MCO documents that no other network or out-of-network provider is accessible within the 30 minutes and 30 miles standard, (Attachment B, II-M-6-a). For out-of-network hospitals that have signed the Hospital Access Agreement with the MDCH, accessible and authorized services ordered by a physician with admitting privileges may take**

place at any time, (See Attachment P, Hospital Access Agreement). All beneficiaries may seek emergency care at any hospital emergency department, (network or out-of-network without authorization).

6. _X_ Mental Health (please describe your standard): **The Mental Health Benefit, outside of 20-outpatient visit, is not the responsibility of the MCO, but is the responsibility of the Community Mental Health Service Providers, CMHSPs operating under a separate waiver from CMS. (Attachment B, CHCP Contract, Section II-H-3 and Section II-I-18). The CHCP Contract requires coordination between the MCO and appropriate CMHSPs serving in the same area. A Model Coordination Agreement is included as part of the Contract and the on-site assessment determine the current status of each agreement as well as the arrangements that the MCO has made to deliver the 20-visit benefit.**

7. _X_ Substance Abuse Treatment Providers (please describe your standard): **Since Substance Abuse Services are not covered under the CHCP Program but are delivered through CMHSPs, the same arrangements are in place as described above.**

8. ___ Dental (please describe your standard):

9. ___ Other providers (please describe your standard):

10. X Please explain how often and how the State monitors compliance and what incentives/sanctions/enforcement the State makes with each of the standards described above. **Monitoring takes place through a variety of administrative processes including:**

- **On-site reviews (see Attachment J, Site Visit Survey Tool, criterion 2.20);**
- **Review of MICHIGAN ENROLLS provider file report and available provider capacity report;**
- **Complaint/grievance information, and**
- **Review of Encounter Data and other utilization reports.**

Depending on the nature of the issue regarding the standards and network availability, enforcement has generally begun with freezing enrollment or automatic enrollment assignments pending a specific further review of issues. Other action would lead to termination of service area approval. Other potential Contract remedies are outlined in the CHCP Contract, (Section II-W).

11. X Please explain how the distance and travel time to obtain services under the waiver will not be further or longer than prior to the waiver. **Prior to the waiver, there was no standard in place. There remains no standard in place for the fee-for-service program. Therefore, with the CHCP Program, accountability is in place with a single contracting entity. With the Managed Care program and waiver, compliance against an objective measure is now possible as well as the ability to assess change over time. There have been no changes made to the standard of 30 minutes from the previous waiver.**

12. X Please explain how the MCOs/PHPs will be required to enable enrollees to access providers. **The Contract (see Attachment B, II-M-6) outlines the expectations for MCO performance in this area. MCOs are then reviewed by the on-site process (see Attachment J, Site Visit Survey Tool), and monitored by review of provider files, changes in capacity, complaint/grievance information, and beneficiary surveys.**

b. Appointment Scheduling (Appointment scheduling means the time before an enrollee can acquire an appointment with his or her provider for both urgent and routine visits.) The State has established standards for appointment scheduling for MCO/PHP enrollee's access to the following. Check any that apply (1-9). For each item checked, please describe the standard and answer monitoring questions 10 and 11.

1. X PCPs (please describe your standard): **The Contract with MCOs contains the following provision: MCOs will monitor waiting times to get appointments with providers as well as the length of time actually spent waiting to see a provider. The MCO will have established criteria for monitoring appointment scheduling for routine and urgent care and for monitoring waiting times in provider offices. These criteria must be submitted to MDCH upon request, (See Attachment B, Contract, II-M-6-l).**

2. X Specialists (please describe your standard): See **response to 1. above.**

3. ___ Ancillary providers (please describe your standard):

4. ___ Pharmacies (please describe your standard):

5. ___ Hospitals (please describe your standard):

6. ___ Mental Health (please describe your standard):

7.___ Substance Abuse Treatment Providers (please describe your standard):

8.___ Dental (please describe your standard):

9.___ Other providers (please describe your standard):

10. X Please explain how often and how the State monitors compliance and what incentives/sanctions/enforcement the State makes with each of the appointment scheduling standards checked above. **See response to No. 1 above. The State monitors the health plans appointment scheduling standards through its site visits and surveys. The consumer survey composite score for getting needed care and getting care quickly address appointment access. Also, the CHCP Program reviews the compliance of this part of the CHCP Contract through the formal annual on-site visits. Failure to comply with the on-site review criteria will result in potential monetary fine as described in Section II-W.**

11. X Please explain how often and how the State assures that appointment scheduling time frames are not longer than the non-waiver appointment scheduling. **As noted earlier, there were no standards in place prior to the Waiver program for managed care—and there is no standard yet for the Fee-for-service Program. Under the CHCP Contract (see attachment B, II-M, 6), the MDCH requires each MCO to develop its own standard and then monitors compliance against that standard. Standards are now in place and the state has a mechanism to assure compliance. The State monitors the health plans compliance upon request and through its annual onsite reviews (see Attachment J, criterion 2.20). Also the consumer surveys 'getting needed care and getting care quickly' composite addresses the issues of appointment access.**

c. In-Office Waiting Times: The State has established standards for in-office waiting times for MCO/PHP enrollee's access to the following. Check any that apply (1-9). For each item checked, please describe the standard and answer monitoring questions 10 and 11.

1. X PCPs (please describe your standard): **The Contract with MCOs contains the following provision: MCOs will monitor waiting times to get appointments with providers as well as the length of time actually spent waiting to see a provider. The MCO will have established criteria for monitoring appointment**

scheduling for routine and urgent care and for monitoring waiting times in provider offices. These criteria must be submitted to MDCH upon request, (See Attachment B, Contract, II-M-6-l).

2. X Specialists (please describe your standard): **See response to 1. above**.

3. ___ Ancillary providers (please describe your standard):

4. ___ Pharmacies (please describe your standard):

5. ___ Hospitals (please describe your standard):

6. ___ Mental Health (please describe your standard):

7. ___ Substance Abuse Treatment Providers (please describe your standard):

8. ___ Dental (please describe your standard):

9. __ Other providers (please describe your standard):

10. X Please explain how often and how the State monitors compliance and what incentives/sanctions/enforcement the State makes with each of the in-office waiting time standards checked above. **See response to 1. above. Also, the MDCH reviews the compliance of this part of the Contract through the formal annual on-site visits (see Attachment J, Site Visit Survey Tool, criterion 2.20). Failure to comply will result in potential monetary fine as outlined in CHCP Contract, (Section II-W).**

11. X Please explain how the State assures that in-office waiting times are not longer than the non-waiver in-office waiting times. **As noted earlier, there were no standards in place prior to the Waiver program for the managed care program and there are no standards yet in place for the Fee-for-service Program. Under the CHCP Contract, the CHCP Program requires each MCO to develop its own standard and then monitors compliance against that standard. Consequently, standards are now in place and the state has a mechanism to assure compliance. The CAHPS survey is performed for both fee-for-service and managed care enrollees. MDCH can use results to compare the two populations on appointment access measures.**

II. Access and Availability Monitoring: Enrollee access to care will be monitored as part of each MCO/PHP's Internal Quality Assurance Plan (QAP), annual external quality review (EQR), periodic medical audits, or Independent Assessments (IA).

Previous Waiver Period

a.___ During the last waiver period, the access and availability monitoring was operated differently than described in the waiver governing that period. The differences were:

b._X_ [Required for all elements checked in the previous waiver submittal] Please include the results from monitoring MCO/PHP access and availability in the previous two year period. [item B.II in the 1999 initial preprint; items B.4, 5, and 6 in the 1995 preprint]. **See Attachment K, EQRO Reports, Attachment L, CAHPS, and Attachment F, Michigan Comp Plan On-Site Review Report, Section 4.**

Upcoming Waiver Period -- For items a. through o. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Check below any of the following (a-o) that the State will also utilize to monitor access:

a._X_ Measurement of access to services during and after a MCO/PHP's regular office hours to assure 24-hour accessibility, 7 days a week (e.g., PCPs' 24-hour accessibility will be monitored through random calls to PCPs during regular and after office hours)

b._X_ Determination of enrollee knowledge on the use of managed care programs

c._X_ Ensures that services are provided in a culturally competent manner to all enrollees.

d._X_ Review of access to emergency or family planning services without prior authorization

e._X_ Review of denials of referral requests

f._X_ Review of the number and/or frequency of visits to emergency rooms, non-authorized visits to specialists, etc., for medical care.

g._X_ Periodic enrollee experience surveys (which includes questions concerning the enrollees' access to all services covered under the waiver)

will be mailed to a sample of enrollees. Corrective actions taken on deficiencies found are also planned.

h. _X_ Measurement of enrollee requests for disenrollment from a MCO/PHP due to access issues

i. _X_ Tracking of complaints/grievances concerning access issues

j. _X_ Geographic Mapping detailing the provider networks against beneficiary locations will be used to evaluate network adequacy. (Please explain). **Geographical mapping is provided to the State by MCOs as part of the initial service area approval process. The determination of service area is made for the State of Michigan by the Office of Financial and Insurance Services (OFIS). OFIS uses a mapping program developed by the Michigan Department of Transportation as part of their final service area decisions. Once Service areas are approved by OFIS, providers included in this assessment are then included in the Provider Files maintained by MICHIGAN ENROLLS. When changes occur in the network, the provider files is modified and the CHCP Program is informed.**

k. _X_ Monitoring access to prescriptions on the State Plan Formulary, Durable Medical Equipment, and therapies.

l. _X_ During monitoring, the State will look for the following indications of access problems.

1. _X_ Long waiting periods to obtain services from a PCP.
2. _X_ Denial of referral requests when enrollees believe referrals to specialists is medically necessary.
3. _X_ Confusion about how to obtain services not covered under the waiver.
4. _X_ Lack of access to services after PCP's regular office hours.
5. _X_ Inappropriate visits to emergency rooms, non-authorized visits to specialists, etc., for medical care.
6. _X_ Lack of access to emergency or family planning services.
7. _X_ Frequent recipient requests to change a specific PCP.
8. ____ Other indications (please describe):

m. _X_ Monitoring the provision and payment for transportation for beneficiaries to get to their outpatient, medically necessary mental health services.

n. _X_ Monitoring the provider network showing that there will be providers within the distance/travel times standards.

o.___ Other (please explain):

III. Capacity Standards

Previous Waiver Period

a.___ During the last waiver period, the capacity standards were operated differently than described in the waiver governing that period. The differences were:

b. X [Required] MCO/PHP Capacity Standards. The State ensured that the number of providers under the waiver remained approximately the same or increased compared to the number before the implementation of the waiver. Please describe the results of this monitoring. **(See Attachment M, CAP Reports). At the time of the initial CHCP waiver, The MDCH monitored the number of providers who were participants in the previous PCCM program to determine how many were contracted providers with MCOs. That assessment indicated about 85% of providers under PCCM continued as a provider with one or more MCO. In 1997 there were 1,622 primary care physicians contracted with MCOs in Wayne, Oakland and Macomb counties. This is a ratio of 1 PCP for every 255 beneficiaries. In May of 2000, that number was 1,699 and a ratio of 1:215. In April of 2002, that number remains about the same, 1,681 and the ratio is 1:208. These are unduplicated numbers and would suggest that the implementation of the CHCP program has not had a negative impact on provider participation. Additionally, the number of providers listed in the Provider Files maintained by Michigan Enrolls is reviewed periodically to determine overall capacity for the State, by county, region and statewide. Comparisons are made to ratios used to establish health professional shortage areas. The most current statewide ratio is less than 1 PCP for every 100 members compared to 1:1500 which is the starting ratio used for shortage area, demonstrating that capacity is more than adequate.**

c.___ [Required if elements III.a.1 and III.a.2 were marked in the previous waiver submittal] The State has monitored to ensure that enrollment limits and open panels were adequate and that provider capacity remained approximately the same or improved under the waiver. Please describe the results of this monitoring.

Upcoming Waiver Period -- For items a. through c. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Please describe the capacity standards for the upcoming two-year period. **(See Attachment N, Michigan Independent Assessment Reports, Provider Capacity Monitoring, pg. 28.)**

a. MCO/PHP Capacity Standards

1. _X_ The State has set enrollment limits for the MCO/PHPs. Please describe a) the enrollment limits and how each is determined and b) a description of how often and through what means the limits are monitored and changed. **(See Attachment M, CAP Reports) The Competitive Bid process, resulting in the most recent Contract, effective October 1, 2000 included proposed capacity limits per county. The capacity limits were either accepted as presented or modified in the Competitive bid approval process. Subsequently, as part of the Provider Files required for each service area approval that are maintained for enrollment purposes, the MCO list the specific capacity for each provider. Therefore, when provider capacity is over 80% in a region, the provider is taken off the automatic enrollment and may only receive voluntary enrollment until capacity is increased. A weekly CAP Report is produced by MICHIGAN ENROLLS. The CHCP Program staff meets bi-weekly with MICHIGAN ENROLLS to review these reports and discuss service area changes if necessary.**

2. _X_ The State monitors to ensure that there are adequate open panels within the MCO/PHP. Please describe how often and how the monitoring takes place. **(See Attachment N, Michigan Independent Assessment Report, Provider Capacity Monitoring, pg. 28, and response 1. above.)**

3. _X_ [Required] The State ensures that the number of providers under the waiver is expected to remain approximately the same or increase compared to the number before the implementation of the waiver. Please describe how the State will ensure that provider capacity will remain approximately the same or improve under the waiver. **(See Attachment N, Michigan Independent Assessment Report, Provider Capacity Monitoring, pg. 28.) At the time of the initial CHCP waiver, The MDCH monitored the number of providers who were participants in the previous PCCM program to determine how many were contracted providers with MCOs. That assessment indicated about 85% of providers under PCCM continued as a provider with one or more MCO. In 1997 there were 1,622 primary care physicians contracted with MCOs in Wayne, Oakland and Macomb counties. This is a ratio of 1 PCP for every 255 beneficiaries. In May of 2000, that number was 1,699 and a ratio of 1:215. In April of 2002, that number remains about the same, 1,681 and**

the ratio is 1:208. These are unduplicated numbers and would demonstrate that the implementation of the CHCP program has not had a negative impact on provider participation. Additionally, the number of providers listed in the Provider Files maintained by Michigan Enrolls is reviewed periodically to determine overall capacity for the State, by county, region and statewide. Comparisons are made to ratios used to establish health professional shortage areas. The most current statewide ratio is less than 1 PCP for every 100 members compared to 1:1500 which is the starting ratio used for shortage area, suggesting that capacity is more than adequate.

4. __X__ [Required] For all provider types in the program, list in the chart below for each geographic area(s) applicable to your State, the number of providers before the waiver, during the current waiver period and the number projected for the proposed renewal period. **Please provide a definition of your geographic area,** i.e. by county, region or capitated rate area. Please complete only for the providers included in your waiver program. **(See Attachment N, Michigan Independent Assessment Report, Provider Capacity Monitoring, pg. 28, and response 1. above.)**

For risk-comprehensive programs, please modify to reflect your State's program and complete the following chart:

Providers	# Before the Waiver	# In Current Waiver	# Expected in Renewal
FQHCs	?	33	33
Hospitals	?	180	180
Pharmacies	?	2,099	2,099
Primary Care Providers (Please specify) - Family Practice - Internal Medicine - OB/GYNs - Pediatricians - Physician Extenders		5,021 2,452 1,507 144 864 107	Same as under current Waiver
Other (please specify)		127	127

*Please note any limitations to the data in the chart above here: **Information is based on contracted provider network. The MCOs have relationships with a number of additional providers outside of a contract. Therefore, beneficiaries will have access to more providers than those listed above. The Geographic area used for service area approvals by the State is based on zip codes and may constitute partial or total counties**

For other risk programs, please modify for your State's program and complete the following chart**: It is assumed the following chart is not applicable for the CHCP program. Implementation of the CHCP program will have no impact on the operation of the other risk programs. The number of providers is not affected**.

Providers	# Before the Waiver	# In Current Waiver	# Expected in Renewal
Developmental Disabilities Providers (please specify)			
Hospitals			
Mental Health Providers (please specify)			
Pharmacies			
Substance Abuse Treatment & Rehab Providers (please specify)			
Transportation Providers (please specify)			
Vision Providers			
Other (please specify)			

*Please note any limitations to the data in the chart above here:

b. **PCP Capacity Standards**

1. The State has set capacity standards for PCPs within the MCOs/PHP expressed in the following terms (In the case of a PHP, a PCP may be defined as a case manager or gatekeeper):

   i.__X__ PCP to enrollee ratio
   ii.___ Maximum PCP capacity

iii. _X_ For PCP contracts with multiple plans, please describe any efforts the State is making to monitor unduplicated Medicaid enrollment capacity across plans? **The CHCP Contract requires MCOs to submit and update their contracted provider files to MICHIGAN ENROLLS. As a result, the CHCP program has the ability to sort the provider information in many different ways and to accommodate unduplicated counts. (See Attachment N, Michigan Independent Assessment Report, Provider Capacity Monitoring, pg. 28, and response 1. above.)**

2.___ The State ensures adequate geographic distribution of PCPs within MCO/PHPs. Please explain.

3._X_ The State designates the type of providers that can serve as PCPs. Please list these provider types. **As defined in the Contract (Definitions) a PCP may be any of the following: family practice physician, general practice physician, internal medicine physician, OB/GYN specialist, pediatric physician when appropriate for an Enrollee, other physician specialists when appropriate for an Enrollee's health condition, nurse practitioner and physician assistants. The MCO may permit the enrollee to choose a "clinic" as a PCP.**

c. Specialist Capacity Standards

1._X_ The State has set capacity standards for specialty services. Please explain. **At the present, MDCH does not have specific capacity standards for specialists for the Fee-for-service Program and consequently, the CHCP does not specify a standard. The CHCP Program does require that MCOs provide access to appropriate providers, including qualified specialists for all medically necessary services including those specialist described under model agreements for behavioral health and developmental disabilities. In addition, the CHCP Program requires reasonable access to specialists. The CHCP Contract will allow a specialist to perform as a PCP when the enrollee's medical condition warrants management by a physician specialist. This may be necessary for enrollees with conditions such as HIV/AIDS, diabetes, end-stage renal disease or other chronic diseases of disability. The need for management by a physician specialist should be determined on a case-by case basis. (Attachment B, CHCP Contract, Section II-M-6-i).**

In the case of pregnant woman, MDCH requires that the MCO

will ensure that a maternity care provider is designated for an enrolled pregnant woman for the duration of her pregnancy and postpartum care. An individual provider must be named as the maternity care provider to assure continuity of care. (Attachment B, CHCP Contract, Section II-M-6-i)

2 _X_ The State monitors access to specialty services. Please explain how often and how monitoring is done. **Monitoring is conducted as part of the annual formal on-site reviews and the ongoing assessment of provider network adequacy conducted with MICHIGAN ENROLLS. Studies of specialty access are components of the focused EQR studies, i.e., HIV/AIDS.**

3. _X_ The State requires particular specialist types to be included in the MCO/PHP network. Please identify these in the chart below, modifying the chart as necessary to reflect the specialists in your State's waiver. Please describe the standard if applicable, e.g. specialty to enrollee ratio. If specialists types are not involved in the MCO/PHP network, please describe how arrangements are made for enrollees to access these services (for waiver covered services only).

For initial service area approval, MCOs must document all contracted specialists and PCPs. Based on the region of the State, it may be appropriate to have regional contracts for certain specialist because of volume and utilization issues. Each of the providers listed below are reviewed to determine if there is contracted capacity for the MCO. The MCO also is required to attest that they will provide transportation and other arrangements to any appropriate specialist necessary for the care of an enrollee. Based upon an assessment of the number of contracted specialist and attestation of the MCO, determinations are made on the approval of a service area. The contracted providers, including specialists are then included in the Provider Files submitted to MICHIGAN ENROLLS.

Specialist Provider Type	Adult	Pediatric
Addictionologist and/or Certified Addiction Counselors		
Allergist/Immunologist		
Cardiologist		
Chiropractors		
Dentist		
Dermatologist		
Emergency Medicine specialist		
Endocrinologist		
Gastroenterologist		
Hematologist		
Infectious/Parasitic Disease Specialist		
Neurologist		
Obstetrician/Gynecologist		
Oncologist		
Ophthalmologist		
Orthopedic Specialist		
Otolaryngologist		
Pediatrician		
Psychiatrist		
Pulmonologist		
Radiologist		
Surgeon (General)		
Surgeon (Specialty)		

Specialist Provider Type	Adult	Pediatric
Other mental health providers (please specify)		
Other dental providers(please specify)		
Other (please specify)		

IV. Capacity Monitoring

Previous Waiver Period

a.___ During the last waiver period, the capacity monitoring was operated differently than described in the waiver governing that period. The differences were:

b._X_ [Required for all elements checked in the previous waiver submittal] Please include the results from monitoring the MCO/PHP capacity in the previous two-year period [item B.IV in the 1999 initial preprint; items A.15-16 in the 1995 preprint]. **(See Attachment M, Capacity Reports)**

Upcoming Waiver Period -- For items a. through l. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response.
Please indicate which of the following activities the State employs:

a.___ Periodic comparison of the number and types of Medicaid providers before and after the waiver.

b.___ Measurement of referral rates to specialists.

c._X_ Provider-to-enrollee ratios

d._X_ Periodic MCO/PHP reports on provider network

e.___ Measurement of enrollee requests for disenrollment from a plan due to capacity issues

f._X_ Tracking of complaints/grievances concerning capacity issues

g.___ Geographic Mapping (please explain)

i.___ Tracking of termination rates of PCPs

j.___ Review of reasons for PCP termination

k. _X_ Consumer Experience Survey, including persons with special needs, (CAHPS)

l.__ Other (Please explain):

V. Continuity and Coordination of Care Standards

Previous Waiver Period

a.___ During the last waiver period, the continuity and coordination of care standards were operated differently than described in the waiver governing that period. The differences were:

Upcoming Waiver Period -- For items a. through h. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Check any of the following that the State requires of the MCO/PHP:

a. _X_ Each enrollee selects or is assigned to a primary care provider appropriate to the enrollee's needs. **Under the CHCP Contract, the MCO must offer its enrollees freedom of choice in selecting a PCP. If the MCO cannot honor the enrollee's choice of the PCP, the MCO must contact the enrollee to allow the Enrollee to either make a choice of an alternative PCP or to disenroll. The MCO will have written policies and procedures describing how enrollees are assigned to a PCP, and how they may change their PCP. If the enrollee does not select their PCP at the time of enrollment with MICHIGAN ENROLLS, it is the MCOs responsibility to assign a PCP within one month of the effective date of enrollment. The CHCP Contract, Section II-M-6-a and Section II-M-6-i, list other PCP requirements.**

b. _X_ Each enrollee selects or is assigned to a designated health care practitioner who is primarily responsible for coordinating the enrollee's overall health care. **See description above**.

c. _X_ Health education/promotion. Please explain. **In addition to the general requirement to provide Health Education services, (See Attachment B, Contract, Enhanced Services, II-H-2), the MCO is required to do the following:**

- **Place strong emphasis on programs to enhance the general health and well being of Enrollees;**
- **Make available health promotion programs to the Enrollees;**
- **Promote the availability of health education classes for Enrollees;**
- **Consider providing education to Enrollees, with or at risk for, a specific disability; and**

- **Consider providing education to Enrollees, Enrollee's families, and other health care providers about early intervention and management strategies for various illnesses and/or exacerbations related to that disability or disabilities.**

d. _X_ Each provider maintains, for Medicaid enrollees, health records that meet the requirements established by the MCO/PHP, taking into account professional standards

e. _X_ There is appropriate and confidential exchange of information among providers.

f. _X_ Informs enrollees of specific health conditions that require follow-up and, if appropriate, provides training in self-care

g.___ Deals with factors that hinder enrollee compliance with prescribed treatments or regimens.

h.__ Case management (please define your case management programs)

VI. Continuity and Coordination of Care Monitoring

Previous Waiver Period

a.___ During the last waiver period, the continuity and coordination of care monitoring was operated differently than described in the waiver governing that period. The differences were:

b. _X_ [Required for all elements checked in the previous waiver submittal] Please include the results from monitoring continuity and coordination of care in the previous two year period [item B.VI in the 1999 initial preprint; Section B (as applicable) in 1995 preprint].

c. _X_ [Required for all elements checked in the previous waiver submittal] Please describe any continuity or coordination of care requirements (i.e., information sharing requirements or any efforts that the State has required to avoid duplication of services) with these entities that the State required during the previous waiver period for the entities marked in B.VI in the previous waiver submission. These requirements do not include monitoring efforts. **There are several instances where both continuity of care arrangements and coordination of care are facilitated. Occasionally, the CHCP Program will be involved in the movement of beneficiaries from one health plan to another. This is a process we refer to as "plan to plan transfer". Under this arrangement the receiving MCO, must complete and submitted a "continuity of care" agreement to their respective CHCP Contract Manager. This**

"continuity of care" agreement requires the MCO to agree to previously arranged referrals, prior authorizations, and related care until the episode of care is completed. Procedures for participating in a "plan to plan" transfer are well known to the contracting HMOs and required substantial overlap of contracted provider networks, adequate lead time to implement such changes and agreement by both the sending and receiving HMO of certain responsibilities, including beneficiary notification of changes, (prior approved by MDCH). Under Coordination of Care, the CHCP Contract refers to several requirements. The first is the coordination of care agreements between the Contracting HMO and Contracting CMHSPs who contract with the DCH. An additional example is the coordination arrangements for long term care. Under Section II-U-4-c-vi of the CHCP Contract, the HMO is required to involve the DCH in the discharge planning for beneficiaries who are candidates for custodial care in a nursing facility. The purpose of this provision is to assure that all appropriate arrangements, including coordination of care, are in place for the care of such beneficiaries.

d.___ [Required for all elements checked in the previous waiver submittal if this is a PHP mental health, substance abuse, or developmentally disabled population waiver] Please describe the State's efforts during the previous waiver period to ensure that primary care providers in FFS, PCCM or MCO programs and PHP providers are educated about how to detect MH/SA problems for both children and adults and where to refer clients once the problems are identified. Please describe the requirements for coordination between FFS, PCCM, or MCO providers and PHP providers. Please describe how this issue is being addressed in the PHP program.

e.___ [Required if this is a PHP mental health, substance abuse, or developmentally disabled population waiver] Please describe how pharmacy services prescribed to program enrollees are monitored in this waiver program. In addition, please note if pharmacy services are not covered under this program.

Upcoming Waiver Period -- For items a. through c. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Please describe how standards for continuity and coordination of care will be monitored in the upcoming two year period.

a. How often and through what means does the State monitor the coordination standards checked above? **The DCH determines compliance for required coordination of care with CMHSPs on an annual basis as part of the site visit and will be instituting measures this year to determine the clinical impact of these arrangements.**

b. Specify below any providers (which are excluded from the capitated waiver) that the State explicitly requires the MCO/PHP to coordinate health care services excluded from the capitated waiver with:

1. _X_ Mental Health Providers (please describe how the State ensures coordination exists): **The MDCH requires both MCOs and Community Mental Health Service Providers, CMHSPs to enter into coordination agreements that will address how shared responsibilities will be addressed.**

2. _X_ Substance Abuse Providers (please describe how the State ensures coordination exists**): Michigan operates the Substance abuse program through contracts with CMHSPs—coordination agreements with CMSHPs will also facilitate coordination with Substance Abuse providers.**

3. _X_ Local Health Departments (please describe how the State ensures coordination exists): **The MDCH recommends a model agreement be used in coordination with Local Health Departments. Further, under the Contract Local Health Departments may provide certain preventive services, (Immunizations and other communicable disease service) without prior authorization from the MCO and the MCO must reimburse at prevailing Medicaid rates. The MDCH also provides with funding for Local Health Departments to assist with Medicaid outreach programs, particularly for EPSDT, Maternal Support programs and prenatal care.**

4. _X_ Dental Providers (please describe how the State ensures coordination exists): **Under the EPSDT requirements, MCOs must refer enrollees to Dental providers in order to obtain needed care. Coordination for Adult Dental Services is facilitated by information provided by MDCH to MCOs regarding contracted providers with the Medicaid program.**

5. ___ Transportation Providers (please describe how the State ensures coordination exists):

6. ___ HCBS (1915c) Service (please describe how the State ensures coordination exists):

7. _X_ Developmental Disabilities (please describe how the State ensures coordination exists): **Developmental Disabilities services are provided by Community Mental Health Service Programs. The MDCH requires both the CMHSPs and MCOs to enter into**

coordination agreements to facilitate services to enrollees entitled to the benefit from both programs.

8. _X__ Title V Providers (please describe how the State ensures coordination exists): **The DCH operates a separate program for Title V/Title XIX beneficiaries referred to as the Children's Special Health Care Services, CSHCS, Program. CSHCS operates both a FFS and managed care model. Under terms of the CHCP Contract, any Medicaid beneficiary that is enrolled in CSHCS is automatically ineligible to be enrolled in the CHCP program and are therefore disenrolled. Many of the providers of CSHCS also participate in the CHCP program, and CHCP Contracted HMOs may assist the DCH in the determination of Medical Eligibility—since the HMO is frequently more familiar with the care needs of the beneficiary than the DCH. Over the past several years, approximately 2,200 CHCP enrolled members have been transferred annually to the CSHCS program. (See Attachment V, DCH Administrative Letter on CSHCS enrollment).**

9. _X_ Women, Infants and Children (WIC) program. **The DCH has identified several model immunization programs for Contracting HMOs that coordinate with WIC Clinics and is working with both the WIC Clinic staff and Contracting HMOs to facilitate more collaboration.**

10. _X_ Indian Health Services providers. **Under terms of the CHCP Contract, Native Americans are a voluntary enrollment only status group. Several of the contracting HMOs, particularly in the Upper Peninsula, used the Indian Health Service as part of their provider network**.

11. _X_ FQHCs and RHCs not included in the program's networks. **Under terms of the CHCP Contract, if the FQHC is the only FQHC is a service area, (county) and the Contracting HMO does not contract with the FQHC, then the HMO is responsible for the full cost charges of the FQHC services. (See Attachment B, CHCP Contract, Section II-I-5. The CHCP Program does not have a similar provision for RHCs, however, many of the RHCs are participants of the provider networks of the Contracting HMOs.**

12. ___ Other (please describe):

Section C. QUALITY OF CARE AND SERVICES

A Section 1915(b) waiver program may not substantially impair enrollee access to medically necessary services of adequate quality. In addition, 1915(b) waiver programs which utilize MCOs or PHPs must meet certain statutory or regulatory requirements addressing quality of health care. This section of the waiver submittal will document how the State has monitored and plans to meet these requirements.

I. Elements of State Quality Strategies: -- This section provides the State the opportunity to describe the specifications it has implemented to ensure the delivery of quality services. To the extent appropriate, the specifications address quality considerations and activities for special needs populations.

Previous Waiver Period

a.___ During the last waiver period, the Elements of State Quality Strategies were different than described in the waiver governing that period. The differences were:

b._X_ [Required] Describe the results of monitoring MCO/PHP adherence to State standards for internal Quality Assurance Programs during the previous two-year period [item C.I.b in 1999 initial preprint; Item B.1 in 1995 preprint]. **(See Attachment I, Performance Standards, Attachment J, Site Visit Survey Tool, Attachment O, HEDIS Results, Attachment L, CAPHS Results, Attachment K, EQR results)**

c._X_ [Required for MCOs] Summarize the results of reports from the External Quality Review Organization. Describe any follow-up done/planned to address study findings [item C.I.c in 1999 initial preprint; item B.2 in 1995 preprint]. **(See Attachment K, EQR Reports)**

d._X_ [Required for PHPs and MCOs] Describe the results of periodic medical audits, and any follow-up done/planned to address audit findings [item C.I.d in 1999 initial preprint; item B.3 in 1995 preprint]. **(See b. above)**

e._X_[MCOs only] Intermediate sanctions were imposed during the previous waiver period. Please describe. **The CHCP Contract, (See Attachment B, II-W) stipulates that the use of intermediate sanctions, as described in federal law is part of the overall Contract Remedy that may be used by the State. If an intermediate sanction, as described, is used, the MCO will be afforded a hearing before termination of contract and beneficiaries will be notified of such a hearing and be given the ability to disenroll, without cause, if they choose. No intermediate sanctions, as described, were implemented during the previous waiver period. Other Contract remedies were applied during the previous waiver period, including financial penalties, enrollment freezes, and corrective action plans.**

Upcoming Waiver Period -- Please check any of the items below that the State requires. For items a through i, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Note: Elements a - g are requirements for States. Elements c, d and e are required for States that contract with MCOs and element d is required for States, which contract with PHPs. The State:

a. _X_ Includes in its contracts with MCOs/PHPs, the State-required internal QAP standards. Please submit a copy of the State's Quality Assurance and Performance Improvement (QAPI) standards and/or guidelines currently required of MCOs/PHPs in their contracts as an attachment to this section (Attachment C.I.a). **The CHCP Contract, (See Attachment B, Section II-P), requires that each MCO have an ongoing Quality Assessment and Performance Improvement Program that meets the requirements of 42 CFR 434.34. This program will be capable of identifying opportunities to improve the provision of health care services and outcomes of such care for enrollees. The program must also incorporate and address findings of the MDCH site visits, EQR reviews, and various statewide focus studies. The Contract specifies the parameters of the Quality Assessment and Performance Improvement Program. The MDCH reviews this program as part of the annual site visit**.

b. _X_ Monitors, on a continuous basis, MCOs/PHPs adherence to the State standards, through the following mechanisms (check all that apply):

1. _X_ Review and approve each MCOs/PHPs written QAP. Such review shall take place prior to the State's execution of the contract with the MCO/PHP.

2. _X_ Review each MCOs/PHPs written QAP on a periodic schedule after the execution of the contract. Please specific frequency: **annually**

3. _X_ On-site (MCO/PHP administrative offices or service delivery sites) monitoring of the implementation of the QAP to assure compliance with the State's quality standards. Such monitoring will take place (specify frequency) **annually** for each MCO/PHP or attach the scope of work from the EQRO contract as an attachment to this section.

4. _X_ Conducts monitoring activities using (check all that apply):

   (a) _X_ State Medicaid agency personnel

   (b) __ Other State government personnel (please specify):

(c)___ A non-State agency contractor (please specify):

5.__ Other (please specify):

c. _X_ Will arrange for an annual, independent, external review of the quality outcomes and timeliness of, and access to items and services delivered under each MCO contract with the State. Note: Until additional guidance on EQR is released, please refer to existing regulations, State Medicaid Manual guidance, and the Quality Reform Initiative guidance in this area.

1. Please specify the name of the entity:
**** MPRO completed the external quality review studies for the 1998, 1999 and 2000 years. Delmarva Foundation is the contractor who will complete the 2001 and 2002 reviews.**

2. The entity type is:
(a) _X_ A Peer Review Organization (PRO).
(b)___ A private accreditation organization approved by HCFA.
(c) __ A PRO-like entity approved by HCFA.
Health Services Advisory Group (HEDIS analysis), Delmarva Foundation (EQR), and NCS Pearson (Consumer Survey an MCQA certified CAHPS vendor

3. Please describe the scope of work for the External Quality Review Organization (EQR):
(See Attachment R, EQR RFP Work Statement)

d. _X_ Has established a system of periodic medical audits of the quality of, and access to, health care for each MCO/PHP on at least an annual basis. These audits will identify and collect management data (including enrollment and termination of Medicaid enrollees and utilization of services) for use by medical audit personnel. Note: Until additional guidance on EQR is released, please refer to existing regulations, State Medicaid Manual guidance, and the Quality Reform Initiative guidance in this area. States may, at their option, institute EQR reviews for PHPs. These periodic medical audits will be conducted by:

1. The entity type is:
(a)__ State Medicaid agency personnel
(b)__ Other State government personnel (please describe):
(c)_X_ A non-State agency contractor to the State (please describe): (**See Attachment R, EQR RFP Work Statement)**
(d)__ Other (please describe):

2. Please attach the scope of work for the periodic medical audits. **(See Attachment R, EQR RFP Work Statement)**

e. _X_ Has established intermediate sanctions that it may impose if the State makes a determination that an MCO violates one of the provisions below. (Note: does not apply to PHPs).

f. _X_ Has an information system that is sufficient to support initial and ongoing operation and review of the State's QAPI.

g. _X_ Has standards in the State QAPI, at least as stringent as those required in federal regulation, for access to care, structure and operations, quality measurement and improvement and consumer satisfaction.

h.___ Plans to develop and implement the use of QISMC in its quality oversight of MCOs/PHPs? (QISMC is a HCFA initiative to strengthen MCOs/PHPs' efforts to protect and improve the health and satisfaction of Medicare and Medicaid enrollees. The QISMC standards and guidelines are key tools that can be used by HCFA and States in implementing the quality assurance provisions of the Balanced Budget Act (BBA) of 1997. This is strictly a voluntary initiative for States). Please explain which domains will the State be implementing (check all that apply).

1.__ Domain 1 - Quality Assessment and Performance Improvement (QAPI) Program: Date of Implementation _____

2.__ Domain 2 - Enrollee Rights: Date of Implementation _____

3.__ Domain 3 - Health Services Management : Date of Implementation _____

4.__ Domain 4 - Delegation: Date of Implementation _____

i.__ Other (please describe)**:**

II. Coverage and Authorization of Services

Previous Waiver Period

a.___ During the last waiver period, coverage and authorization of services were different than described in the waiver governing that period. The differences were:

b._X_ [Required for all elements checked in the previous waiver submittal] Please provide results from the State's monitoring efforts for compliance in the area of coverage and authorization of services for the previous waiver period, including a summary of any issues/trends identified in the areas of

authorization of services and under/over utilization [items C.II.a-e in 1999 initial preprint; relevant sections of the 1995 preprint]. Please include the results from those monitoring efforts for the previous waiver period. (**See Attachment Q, Onsite Summary Report, and Attachment N, Independent Assessment, Covered Services, p. 18)**

Upcoming Waiver Period -- Please check any of the processes and procedures from the following list that the State requires to ensure that contracting MCOs/PHPs meet coverage and authorization requirements. For items a through e, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Contracts with MCOs/PHPs:

a. _X_ Identify, define and specify the amount, duration and scope of each service offered, differentiating those services, which may be only available to special needs populations, as appropriate.

b. _X_ Specify what constitutes "medically necessary services" consistent with the State's Medicaid State Plan program (i.e., the FFS program). Please list that specification or definition: **(See Attachment B, Contract, II-H-1, pg.21) The Contract includes the following provision for all MCOs: "The covered services that the MCO has available for Enrollees must include, at a minimum, the Covered services listed below. The MCO may limit services to those which are medically necessary and appropriate, and which conform to all applicable Medicaid provider manuals and publications for coverages and limitations."**

c. _X_ Provide that the MCO/PHP furnishes the services in accordance with the specification or definition of "medically necessary services".

d. _X_ Ensure implementation of written policies and procedures reflecting current standards of medical practice and qualifications of reviewers for processing requests for initial authorization of services or requests for continuation of services. Policies include:

1. _X_ Specific time frames for responding to requests,

2. _X_ Requirements regarding necessary information for authorization decisions,

3. ___ Provisions for consultation with the requesting provider when appropriate,

4. _X_ Providing for expedited response for urgently needed services

5. _X_ Clearly documented criteria for decisions on coverage and medical necessity that are based on reasonable medical evidence or a consensus of relevant medical professionals.

6. _X_ Criteria for decision on coverage and medical necessity are updated regularly.

7. ___ Mechanisms to ensure consistent application of review criteria and compatible decisions.

8. _X_ A process for clinical peer reviews of decisions to deny authorization of services on the grounds of medical appropriateness.

9. _X_ Processes and procedures that ensure prompt written notification of the enrollee and provider when a decision is made to deny, limit, or discontinue authorization of services. (Note: current regulations require notice for a termination, reduction, or suspension of services which have already been authorized or when a claim for services is not acted upon with reasonable promptness. This check box should be marked when the State also requires notice when an enrollee's request for future services is denied, limited, or discontinued.) Notices include (check all that apply):

   (a)__ Criteria used in denying or limiting authorization

   (b)_X_ Information on how to request reconsideration of the decision.

   (c)___ Other (please describe):

10. _X_ Mechanisms that allow providers to advocate on behalf of enrollees within the utilization management process.

11. _X_ Mechanisms to detect both underutilization and over utilization of services.

12. ___ Other (please describe):

e.___ Other (please describe):

III. Selection and Retention of Providers

Previous Waiver Period

a.___ During the last waiver period, the selection and retention of providers were different than described in the waiver governing that period. The differences were:

b. X [Required for all elements checked in the previous waiver submittal] Please provide a description of how often and through what means the State monitored the process for selection and retention of providers checked in the previous waiver submittal [items C.III.a-h in the 1999 initial preprint; relevant sections of the 1995 preprint]. Also please provide results from the State's monitoring efforts for compliance in the area of selection and retention of providers for the previous waiver period. The State monitors, at least annually, the process for selection and retention of providers through the onsite review activity. **There are specific criteria in the onsite review tool that address the selection and retention of providers as follows: the policies and procedures related to provider adequacy (2.19); exclusion of providers terminated, suspended or excluded from Medicaid or Federal Medicare programs (2.18); and the credentialing and recredentialing process of all affiliated providers (4.5). See attachments F, Michigan Comp Plan Onsite Review Report, and J, CHCP Site Visit Survey Tool. Under the Contract, MCOs must inform the MDCH within 7 business days of any change to the composition of the provider network that would affect the MCO's ability to make available all covered services to enrollees in a timely manner. See Attachment B, Contract, II-M-6-e).**

Upcoming Waiver Period

Please check any processes or procedures listed below that the State uses to ensure that each MCO/PHP implements a documented selection and retention process for its providers. For items a through h, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. The State requires MCOs/PHPs to (please check all that apply):

a.___ Develop and implement a documented process for selection and retention of providers.

b. X Have an initial credentialing process for physicians and other licensed health care professionals including members of physician groups that is based on a written application and site visits as appropriate, as well as primary source verification of licensure, disciplinary status, and eligibility for payment under Medicaid.

c. _X_ Have a recredentialing process for physicians and other licensed health care professionals including members of physician groups that is accomplished within the time frames set by the State, and through a process that updates information obtained through the following (check all that apply):

1. _X_ Initial credentialing

2. _X_ Performance indicators, including those obtained through the following (check all that apply):

   (a) _X_ The quality assessment and performance improvement program
   (b) ___ The utilization management system

   (c) _X_ The grievance system

   (d) _X_ Enrollee satisfaction surveys

   (e) ___ Other MCO/PHP activities as specified by the State.

d. ___ Use formal selection and retention criteria that do not discriminate against particular practitioners, such as those who serve high risk populations, or specialize in conditions that require costly treatment.

e. _X_ Determine, and redetermine at specified intervals, appropriate licensing/ accreditation for each institutional provider or supplier. Please describe any licensing/accreditation intervals required by the State **at least every 3 years.**

f. _X_ Have an initial and recredentialing process for providers other than individual practitioners (e.g., home health agencies) to ensure that they are and remain in compliance with any Federal or State requirements (e.g., licensure).

g. _X_ Notify licensing and/or disciplinary bodies or other appropriate authorities when suspensions or terminations of providers take place because of quality deficiencies.

h. ___ Other (please describe):

IV. Delegation

Previous Waiver Period

a.___ During the last waiver period, delegation was different than described in the waiver governing that period. The differences were:

b._X_ [Required for all elements checked in the previous waiver submittal] Please provide results from the State's monitoring efforts for compliance in the area of delegation for the previous waiver period [items C.IV.a-i in 1999 initial preprint; relevant sections of the 1995 preprint]. **The CHCP Program reviews on an annual basis, during the site visit, the status any prior approved delegation of function and determines if any new request has been appropriately approved by state officials. Under terms of the CHCP Contract, (See Attachment B, Sections I-P and I-Q), MCOs may not assign or delegate any of its duties or responsibilities without prior approval of the State Purchasing Director. Further, as all MCOs in Michigan are licensed as HMOs, the Office of Financial and Insurance Services must also approve any delegated function. The CHCP Program coordinates with both offices in the review of delegation requests.**

Upcoming Waiver Period

Please check any of the processes and procedures from the following list that the State uses to ensure that contracting MCOs/PHPs oversee and are accountable for any delegated functions in Section C. Quality of Care and Services. For items a through i, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Where any functions are delegated by MCOs/PHPs, the State Medicaid Agency:

a._X_ Reviews and approves (check all that apply):

1.___ All subcontracts with individual providers or groups

2._X_ All model subcontracts and addendums

3.___ All subcontracted reimbursement rates

4._X_ Other (please describe):
To obtain approval of the State Purchasing Director, the MCO must provide all necessary documentation that demonstrates that the proposed designee meets all of the requirements under the Contract.

b._X_ Requires agreements to be in writing and to specify any delegated responsibilities.

c.___ Requires agreements to specify reporting requirements.

d.___ Requires written agreements to provide for revocation of the delegation or other remedies for inadequate performance.

e. X Monitors to ensure that MCOs/PHPs have evaluated the entity's ability to perform the delegated activities prior to delegation.

f.___ Ensures that MCOs/PHPs monitor the performance of the entity on an ongoing basis.

g. X Monitors to ensures that MCOs/PHPs formally review the entity's performance at least annually.

h.___ Ensures that MCOs/PHPs retain the right to approve, suspend or terminate any provider when they delegate selection of providers to another entity.

i. X Other (please explain):
Health plans are required to be licensed as HMOs. The Office of Financial Insurance Services administers the items a.-h. above.

V. Practice Guidelines

Previous Waiver Period

a.___ During the last waiver period, practice guidelines were different than described in the waiver governing that period. The differences were:

b. X [Required for all elements checked in the previous waiver submittal] Please provide results from the State's monitoring efforts to determine the level of compliance in the area of practice guidelines for the previous waiver period [items C.V.a-h in 1999 initial preprint; relevant sections of the 1995 preprint]. **The CHCP Contract, (See Attachment B, Section II-P-1) requires MCOs to develop an annual written plan for the Quality Assessment and Performance Improvement Program. The parameters for the Plan are outlined in the Contract. Assessment of performance and outcomes related to the Annual Plan are reviewed by the CHCP Program as part of the annual site visit review. This process includes review of practice guidelines. Under the CHPC program, a Clinical Advisory Committee representing each Contracting MCO has been established. The Clinical Advisory Committee has reviewed practice guidelines in areas of concern to the State. The CHCP Program has also reviewed with the Clinical Advisory Committee best practices.**

Upcoming Waiver Period - Please check any of the processes and procedures from the following list that the State requires to ensure that contracting MCOs/PHPs adopt and disseminate practice guidelines (please check all that apply). For items a through h, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Guidelines:

a. _X_ Are based on reasonable medical evidence or a consensus of health care professionals in the particular field.

b. _X_ Consider the needs of the MCOs/PHPs enrollees.

c.___ Are developed in consultation with contracting health professionals.

d. _X_ Are reviewed and updated periodically.

e. _X_ Are disseminated to all providers, all enrollees (as appropriate) and individual enrollees upon request.

f. _X_ Are applied in decisions with respect to utilization management, enrollee education, coverage of services, and other relevant areas.

g.___ Develop and implement policies and procedures for evaluating new medical technologies and new uses of existing technologies.

h.___ Other (please explain):

VI. Health Information Systems

Previous Waiver Period

a.___ During the last waiver period, health information systems of contracting MCOs/PHPs were different than described in the waiver governing that period. The differences were:

b. _X_ [Required for all elements checked in the previous waiver submittal] Please provide results from the State's monitoring efforts for compliance in the area of health information systems for the previous waiver period [items C.VI.a-i in 1999 initial preprint; relevant sections of the 1995 preprint]. MDCH uses an annual site visit structure to review and formally assess compliance with Contract requirements, including health information systems. **(See Attachment Q, On Site Summary Report, Section 5.0 - 5.3)**

c. _X_ Please provide a description of the current status of the State's encounter data system, including timeliness of reporting, accuracy, completeness and

usability of data provided to the State by MCOs/PHPs. **As noted in the CMS site visit report, (See Attachment F), Michigan monitors aggregate encounter data submitted by plans on a monthly basis and views overall service trends. The State uses a utilization profile that provides information on key services in order to track overall volume and distribution of those service types. The State analyzes encounter data to ensure that duplicate records are not being submitted. The MDCH uses a semi-annual data quality improvement plan (DQIP) process to improve data submissions and will also conduct data validation audits concurrent with the 2001 EQR. Michigan is in the final phase of development of an Executive Information System/Decision Support System, (EIS/DSS) for conducting additional studies using encounter data. The EIS/DSS will include the development of management reports that will profile the Medicaid program for important eligibility, financial, utilization and clinical dimensions. The EIS/DSS will also provide for a benchmarking capability and the MDCH intends to use this feature to provide information on provider/patient loads, adequacy of network, adjustments for case mix, physician referrals, and evidence of over or under referrals. (See Attachment S, Encounter Data)**

d. _X_ The State uses information collected from MCOs/PHPs as a tool to monitor and evaluate MCOs/PHPs (i.e. report cards). Please describe.
The State uses several tools as follows:

- **Encounter data used in EQR studies and performance standards.**
- **HEDIS, performance goals/benchmarks for consumer guide.**

Under the Contract changes that went into effect on October 1, 2001, MCOs will be assessed regarding their performance in a number of clinical and administrative areas. The performance standards will be revised over the FY 02 Contract year and beginning in FY 03, incentives and contract remedies will begin to be applied relative to each MCO's performance. Several of the Standards rely on encounter data, including well-child visits. (See Attachment I, Performance Standards)

e. _X_ The State uses information collected from MCOs/PHPs as a tool to educate beneficiaries on their options (i.e. comparison charts to be used by beneficiaries in the selection of MCOs/PHPs and/or providers). Please describe**. The MDCH uses the collection of information from audited reports and surveys in order to develop a "consumer guide". This guide provides comparison in key areas for beneficiaries and is included in all new enrollee packets mailed by MICHIGAN ENROLLS. (See Attachment T, Consumer Guide and Attachment N, Independent Assessment Report, Quarterly Monitoring Elements, pg. 35)**

Upcoming Waiver Period
Please check any of the processes and procedures from the following list that the State requires to ensure that contracting MCOs/PHPs maintain a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of the Medicaid Program. For items a through i, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. The State requires that MCOs/PHPs systems:

a. _X_ Provide information on
1. _X_ Utilization,
2. _X_ Grievances,
3. ___ Disenrollment.

b. _X_ Collect data on enrollee and provider characteristics as specified by the State.

c. _X_ Collect data on services furnished to enrollees through an encounter data system or such other methods approved by the State (please describe). The MCO/PHP is capable of (please check all that apply):

1. _X_ [Required] Recording sufficient patient data to identify the provider who delivered services to Medicaid enrollees

2. _X_ [Required] Verifying whether services reimbursed by Medicaid were actually furnished to enrollees by providers and subcontractors
3. _X_ Verifying the accuracy and timeliness of data

4. _X_ Screening data for completeness, logic and consistency

5. _X_ Collecting service information in standardized formats to the extent feasible and appropriate

6. ___ Other (please describe):

d. _X_ Provide periodic numeric data and/or narrative reports describing clinical and related information for the Medicaid enrolled population in the following areas (check all that apply):

1. _X_ Health services (please specify frequency and provide a description of the data and/or content of the reports) **This is collected through the required HEDIS reporting (annual report) (See Attachment O, HEDIS)**

2. _X_ Outcomes of health care (please specify frequency and provide a description of the data and/or content of the reports) **This is**

collected through the required HEDIS and Consumer Survey reports. (See Attachment L, CAHPS and Attachment O, HEDIS)

3. _X_ Encounter Data (please specify frequency and provide a description of the data and/or content of the reports **As noted in the CMS site visit report, Michigan monitors aggregate encounter data submitted by plans on a monthly basis and views overall service trends. The State uses a utilization profile that provides information on key services in order to track overall volume and distribution of those service types. The State analyzes encounter data to ensure that duplicate records are not being submitted. After passing through system edits, all encounters that possess the same autobiller identification number, encounter reference number and line numbers are rejected. MCOs are then asked if the encounter is a true duplicate—if so, the MCO must void the data.**

The MDCH uses a semi-annual data quality improvement plan, DQIP, process to improve data submissions and will also conduct data validation audits concurrent with the 2001 EQR.

Michigan is in the final phase of development of an Executive Information System/Decision Support System, (EIS/DSS) for conducting additional studies using encounter data. The EIS/DSS will include the development of management reports that will profile the Medicaid program across important eligibility, financial, utilization and clinical dimensions. The EIS/DSS will also provide for a benchmarking capability and the MDCH intends to use this feature to provide information on provider/patient loads, adequacy of network, adjustments for case mix, physician referrals, and evidence of over or under referrals. (See Attachment S, Encounter Data)

4. ___ Other (please describe and please specify frequency and provide a description of the data and/or content of the reports)

e. _X_ Maintain health information systems sufficient to support initial and ongoing operation, and that collect, integrate, analyze and report data necessary to implement its QAP.

f. _X_ Ensure that information and data received from providers are accurate, timely and complete.

g. _X_ Allow the State agency to monitor the performance of MCOs/PHPs using systematic, ongoing collection and analysis of valid and reliable data.

h. _X_ Ensure that each provider furnishing services to enrollees maintains an enrollee health record in accordance with standards established by the organization that take into account professional standards.

i.___ Other (please describe):

VII. Quality Assessment and Performance Improvement (QAPI)

Previous Waiver Period

a.___ During the last waiver period, the State's Quality Assessment and Performance Improvement (QAPI) program was different than described in the waiver governing that period. The differences were:

b. _X_ [Required for all elements checked in the previous waiver submittal] Please provide results from the State's monitoring efforts to determine the level of compliance in the area of QAPI for the previous waiver period [items C.VII.a-u in 1999 initial preprint; relevant sections in the 1995 preprint]. Please break down monitoring results by subpopulations if available. **The CHCP Contract, (See Attachment B, Section II-P) requires that each MCO have an ongoing Quality Assessment and Performance Improvement Program that meets the requirements of 42 CFR 434.34. This program will be capable of identifying opportunities to improve the provision of health care services and outcomes of such care for enrollees. The program must also incorporate and address findings of the CHCP Program site visits, EQR reviews, and various statewide focus studies. The Contract specifies the parameters of the Quality Assessment and Performance Improvement Program. The CHCP Program staff reviews this program as part of the annual site visit. See Attachment Q, Onsite Summary Report, Section 4).**

c. _X_ The State or its MCOs/PHPs conducted performance improvement projects that achieve, through on-going measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical care and non-clinical services that can be expected to have a beneficial effect on health outcomes and enrollee satisfaction. Please list and submit findings from the projects completed in the previous two year period. **The CHCP Program initiated several studies on Emergency Department utilization using the research capacity of both the University of Michigan and Michigan State University. The CHCP Program also initiated a focused approach to demonstrating best practices for immunizations in Wayne County. (See Attachment U, Medicaid Emergency Department Project Summary, Attachment H, Wayne County Immunization Project Summary, and Attachment K, EQR Reports)**

Upcoming Waiver Period- Please check any of the processes and procedures from the following list that the State requires to ensure that contracting MCOs/PHPs maintain an adequate QAPI. For items a through u, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. The State requires that MCOs/PHPs (check all that apply and note in narratives if the State intends to break down the results by subpopulation):

a. _X_ Have an adequate organizational structure, which allows for clear and appropriate administration and evaluation of the QAPI. The State has standards, which include (check all that apply):

1. _X_ A policy making body which oversees the QAPI

2. _X_ A designated senior official responsible for program administration and documentation of Quality Improvement committee activities.

3. _X_ Active participation by providers and consumers

4. _X_ Ongoing communication and collaboration among the Quality Improvement policy making body and other functional areas of the organization.

5. ___ Other (please describe):

b. _X_ Measure their performance, using standard measures established or adopted by the State Medicaid agency, and reports their performance to the applicable agency. Please list or attach the standard measures currently required. **(See Attachment I, Performance Measures)**

c. _X_ Achieve required minimum performance levels, as established by the State Medicaid agency on standardized quality measures. Please list or attach the standardized quality measures established by the State Medicaid agency. **(See Attachment I, Performance Measures)**

d. _X_ Conduct performance improvement projects that achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical care and non-clinical services that can be expected to have a beneficial effect on health outcomes and enrollee satisfaction.
Please list the projects currently planned for each year of the waiver period either at a state or plan-level. Please describe the types of issues that are included in clinical (e.g., acute/chronic conditions, high-volume/high-risk services) and non-clinical (e.g., complaints, appeals, cultural competence, accessibility) focus areas as defined by the State.

The State participates in the EPSDT/WIC partnership with health plans, WIC, MSS and local health departments to address issues around EPSDT and maternal outreach assessment, education and outreach. (See Attachment Y, Maternal & Child Work Group). The State is also requiring each health plan to perform quality improvement activities (QIAs) annually. The seven plans that participated in the Wayne County Immunization project are required to continue formal immunization improvement projects. The health plan performance improvement projects for 2002 are as follows:

Health Plan	Performance Improvement Project
Botsford Health Plan	Diabetes Disease Management
Cape Health Plan *	Immunization Initiative Project
Care Choices HMO	Childhood Immunizations
Community Care Plan	Childhood Immunizations
Community Choice of Michigan	Asthma Care Coordination
Great Lakes Health Plan *	Immunization Project
Health Plan of Michigan	Postpartum Intervention Program
Health Plus of Michigan	Improving Well-child Visits for Children
M-Care	Breast Cancer Screening
McLaren Health Plan	Comprehensive Diabetes Care
Midwest Health Plan *	Childhood Immunization Project
Molina Healthcare of Michigan *	Childhood Immunization Project
Omnicare Health Plan *	Childhood Immunization Project
PHP of Mid-Michigan	Improving Rate of Check-ups After Delivery
PHP of Southwest Michigan	MCIR Reporting Compliance by PCP's
Priority Health Plan	Use of Appropriate Medications for People with Asthma
The Wellness Plan *	Immunization Outreach Program
Total Health Care *	Childhood Immunizations
Upper Peninsula Health Plan	Immunization Project

*** Plans in Wayne County Immunization Project**

e. _X_ Correct significant systemic problems that come to its attention through internal surveillance, complaints, or other mechanisms.

f. _X_ Are allowed to collaborate with one another on projects, subject to the approval of the State Medicaid agency.

g. _X_ Are allowed to conduct multi-year projects that meet the improvement standards as described in QISMC or that are specified in a project work plan developed in consultation with the State Medicaid agency.

h. _X_ Select topics for projects through continuous data collection and analysis by the organization of comprehensive aspects of patient care and member services.

i. _X_ Select and prioritize topics for projects to achieve the greatest practical benefit for enrollees.

j. _X_ Select topics in a way that takes into account the prevalence of a condition among, or need for a specific service by, the organization's enrollees; enrollee demographic characteristics and health risks; and the interest of consumers in the aspect of care or services to be addressed.

k. _X_ Provide opportunities for enrollees to participate in the selection of project topics and the formulation of project goals.

l. _X_ Assess and measure the organization's performance for each selected topic using one or more quality indicators.

m. _X_ Base the assessment of the organization's performance on systematic, ongoing collection and analysis of valid and reliable data.

n. ___ Establish a baseline measure of performance on each indicator, measure changes in performance, and continue measurement of at least one year after a desired level of performance is achieved.

o. _X_ Use a sampling methodology that ensures that results are accurate and reflective of the MCOs/PHPs enrolled Medicaid population.

p. _X_ Meet previously-determined standards to define results that show significant demonstrable improvement in performance as evidenced in repeat measurements of the quality indicators specified for each performance improvement project identified.

q. _X_ Use benchmarks levels of performance which are either determined in advance by the State Medicaid agency or by the organization.

r. _X_ Ensure that improvement is reasonably attributable to interventions undertaken by the organization (has face validity).

s. ___ Administer their QAPI through clear and appropriate administrative arrangements.

t. _X_ Formally evaluate, at least annually, the effectiveness of the QAPI strategy, and make necessary changes.

u. ___ Other (please describe):

Section D. Cost Effectiveness

In order to demonstrate cost effectiveness, a waiver renewal request must demonstrate that it was cost-effective during the previous two-year waiver period (Years 1 and 2) and must show that the cost of the waiver program will not exceed what Medicaid costs would have been in the absence of the waiver in the upcoming two-year waiver period (Years 3 and 4).

With respect to waivers involving capitated reimbursement, a State's computation of its UPL (as required by 42 CFR 447.361) may serve the dual purpose of computing the projected Medicaid costs in the absence of the waiver as well. **The UPL is only one component of waiver cost effectiveness, which must also include comparisons of a State's administrative costs and relevant FFS costs with and without the waiver as well.**

HCFA offers the following suggestions to States in completing this section:

- States are strongly encouraged to use the revised waiver preprint format to reduce the number of questions regarding their cost-effectiveness calculations. Please note that use of the revised preprint is optional.

- Cost effectiveness for 1915(b) waivers is measured in total computable dollars (Federal and State share).

- States are not be held accountable for caseload changes when submitting their waiver renewal cost-effectiveness calculations for services. States should have Per Member Per Month (PMPM) costs for the 2-year period equal to or less than projected Without Waiver costs as calculated in Step 18 of Appendix D.IV of their initial preprint. **Please ensure that you are using the PMPM Without Waiver costs that were approved in the previous waiver in your renewal.** In addition, States will also not be held accountable for benefit package, payment rate, or other programmatic changes made to the waiver program.

- Waiver expenditures should be reported on the Quarterly Medicaid Statement of Expenditures (Form HCFA-64 Report), according to reporting instructions in the State Medicaid Manual, Section 2500. If the State has specific questions regarding this requirement, please contact your State's HCFA accountant in the Regional Office.

- A set of sample preprint Appendices has been included with this preprint using Year 2 of one State's experience (DSAMPLE.XLS). Blank Appendices have been included for your use (APPD.XLS). **Please modify the spreadsheets to meet your State's UPL and rate development techniques, using the State's capitated rate cells (most states use eligibility category, age, and gender-adjusted cells)**. If a waiver program does not cover all categories of service, the

State should modify the spreadsheet to include only covered services. Please submit the electronic spreadsheets used to create the Appendices to HCFA (HCFA currently uses Excel, which will convert both Lotus and QuatroPro). Please structure the worksheets as schedules which can link the totals between spreadsheets and roll up into a summary if the State has that capability. Linking the sheets and summaries will reduce copying from one schedule to another, which may introduce errors.

- The costs and enrollment numbers for voluntary populations (i.e., populations which can choose between joining managed care and staying in FFS) should be excluded from the waiver cost-effectiveness calculations if these individuals are not included in the waiver. In general, HCFA believes that voluntary populations should not be included in 1915(b) waivers (i.e., excluded in Section A.II.l and A.II.m). If the State wants to include voluntary populations in the waiver (i.e., listed in Section A.III.b.3), then the costs and enrollment numbers for the population must be included in the cost-effectiveness calculations. In addition, States that elect to include voluntary populations in the waiver are required to submit a written explanation of how selection bias will be addressed in the rate setting or with waiver calculations. HCFA may require the State to adjust its upper payment limits for the voluntary population to account for selection bias.

Description of the Cost-Effectiveness Calculation Process:
In general, the UPL for capitation contracts on a risk basis (e.g., MCO, HIO, or PHP) is the State agency's estimated cost of providing the scope of services covered by the capitation payment if these services were provided on a FFS basis. Documentation for the without waiver costs must be calculated on a per member per month basis.

- In order to determine cost-effectiveness, States must first document the number of member months participating in the waiver program for the previous waiver period (Year 1 and Year 2). They must then estimate the number of member months for the target population which will participate in the waiver program for the upcoming waiver period (Year 3 and Year 4) See Appendix D.II, Steps 1-4. The member months estimation should be based on the actual State eligibility data in the base year and the experience of the program in Year 1 and Year 2.

- The base year and the source of the without waiver data need to be identified for Years 1 - 4. The sources for this data and any adjustments to this data must be listed (Appendix D.III, Steps 5-9). If the State is proposing to use a different methodology for Years 3 and 4, please document all differences between the methodologies. Without Waiver Costs should be created using a FFS UPL based on FFS data with FFS utilization and FFS inflation assumptions. HCFA recommends that a State use at least three years of FFS Medicaid historical data to develop utilization and inflation trend rates.

- Statistically valid (as defined by the State's actuary) without waiver cost and eligibility data for the population to be covered must be established. Base years

should be specific to the eligibility group and locality covered by the contract and, to the extent possible, the costs included in the capitation rates. The exception to this would be where the size of the group is not sufficiently large to represent a statistically valid sample. These base year costs need to be broken down into each of the main service categories covered under the contract--inpatient hospital, outpatient hospital, physician, lab and x-ray, pharmacy, and other costs (Appendix D.IV, Steps 10-13).

- Once the base year costs are established, States need to make adjustments to that data in order to update it to the year to be covered by the capitation contract. These adjustments represent the impact on Medicaid costs from such things as inflation, utilization factors, administrative expenses, program changes, reinsurance or stop-loss limits, and third party liability. When these adjustments are computed and factored into the base year costs, the end result is a projected UPL for the year under contract (Appendix D.IV, Steps 14-16). The State then needs to consider the effect of costs which are outside the capitation rate (and therefore outside the UPL), but are affected by the capitated contractor. These services are generally referred to as wraparound services, and may include such services as pharmacy. Because the capitated contractor can affect the costs of these wraparound services, they must be included in the without waiver cost development (Appendix D.IV, Steps 17-18). Without waiver costs must be developed for all Years 1 - 4.

- States must document actual PMPM costs under the waiver for the previous two-year period. They also must estimate the PMPM costs under the upcoming waiver period. The costs should include services controlled by the waiver but not in the capitated rate, plus the agency's average per capita administrative costs related to these services (Appendix D.V, Steps 19-29).

- States must then calculate the aggregate costs without the waiver and the aggregate costs with the waiver (Appendices D.VI, D.VII, Steps 30-35).

- States must clearly demonstrate that, when compared, payments to the contractor did not exceed the UPL in the past two years and will not exceed the UPL in the future two years (Appendix D.VIII, Steps 36-37), and costs under the waiver did not exceed costs without the waiver costs in the previous period and will not exceed without waiver costs in the future (Appendix D.VIII, Steps 38-40).

Assurance (Please initial or check)

___X____ The fiscal staff in the Medicaid agency has reviewed these calculations for accuracy and attests to their correctness.

Name of Medicaid Financial Officer: Dave Viele

Telephone Number: (517) 241-1193

The following questions are to be completed in conjunction with the Worksheet Appendices. We have incorporated step-by-step instructions directly into the worksheet using instruction boxes. Where further clarification was needed, we have included additional information in the preprint. All narrative explanations should be included in the preprint.

I. Type of Contract The response to this question should be the same as in **A.II.e**.

a._X_ Risk-comprehensive (fully-capitated--MCOs, HIOs, or certain PHPs)
b.___ Other risk (partially-capitated--PHP)
c.___ Non-risk. Please use Section C of the PCCM initial application.
d.___ Other (please explain):

II. Member Months: Appendix D.II.

Purpose: To provide data on actual and projected enrollment during the waiver period. Actual enrollment data for the previous waiver period must be obtained from the State's tracking system. Projected enrollment data for the upcoming period is needed to determine whether the waiver is likely to be cost effective. This data is also useful in assessing future enrollment changes in the waiver.

Step 1: Please list the rate cells which were used in setting capitation rates under the waiver. The number and distribution of rate cells will vary by State. If the State used different cells in Years 1 & 2 than in Years 3 & 4, please create separate tables for the two waiver periods. The base year should be the same as the FFS data used to create the PMPM without waiver costs. Base year eligibility adjustments such as shifts in eligibility resulting in an increase or decrease in the number of member months enrolled in the program should be noted here. Note: because of the timing of the waiver renewal submittal, the State may need to estimate up to six (6) months of enrollment data for Year 2 of the previous waiver period.

Step 2: See instruction box. If the State estimates that all eligible individuals will not be enrolled in managed care (i.e., a percentage of individuals will be unenrolled because of eligibility changes and the length of the enrollment process) please note the adjustment here.

Step 3: See instruction box. In the space provided below, please explain any variance in member months, by region, from Year 1 to Year 4.

Step 4: See instruction box. In the space provided below, please explain any variance in total member months from Year 1 to Year 4.

a. Population in base year data

1. _X_ Base year data is from the same population as to be included in the waiver.

2. ___ Base year data is from a comparable population to the individuals to be included in the waiver. (Include a statement from an actuary or other explanation which supports the conclusion that the populations are comparable.)

III. Without Waiver Data Sources and Adjustments: Appendix D.III.

Purpose: To explain the data sources and reimbursement methodology for base year costs.

To identify adjustments, which must be made to base year costs, in order to arrive at the UPL for capitated services and the without waiver costs for all waiver services.

NOTE: The data on this schedule will be used in preparing **Appendix D.IV Without Waiver Cost Development**. Also, it is acceptable to use encounter data or managed care experience to develop with waiver costs or set capitated rates (see Section D.V). At this time, it is not acceptable to use experience data to develop without waiver costs. A workgroup has been formed to examine this policy. This submittal will be updated based upon the outcome of that workgroup.

NOTE: If the State is proposing to use a different methodology for Years 3 and 4 than were used in Years 1 and 2, please document all differences between the methodologies.

Regional Offices approve annual UPLs and contract rates developed by States. They are authorized to approve UPLs and contract rates that fall under the methodologies granted under the original and subsequent waiver authority. Modifications to the UPL development methodology should be approved through a waiver modification as explained in the instructions to this submittal.

Step 5: Actual cost and eligibility data are required for base year PMPM computations. Specify whether the base year is a State fiscal year (SFY), Federal fiscal year (FFY), or other period. **Please note the waiver years that this methodology was in place. Submit separate Appendix D.III charts if different methodologies or services were used in the Without Waiver costs for the**

upcoming waiver period than in the previous waiver period. Please provide an explanation in the space below if: a) multiple years are used as the base year; or b) data from sources other than the State's MMIS are used.

Step 6: See instruction box. This chart should be identical to the chart in Section A.III.d.1.

Step 7: **UPL Adjustments:** On Appendix D.III check all adjustments that apply to base year data.

Step 8. **Fee-For-Service Wraparound Cost Adjustments**: See instruction box.

Instructions For Steps 7 and 8 above:

Required Adjustments a. through g. (below) and Appendix D.III must be completed by all States. Optional Adjustments a. through l. (below) should be completed if the adjustment applies to your State. For each Optional Adjustment that does not apply, the State should note if they have made a policy decision to not include that adjustment. If the State has made an adjustment to its without waiver cost, information on the basis and methodology information below must be completed and mathematically accounted for in Appendix D.IV. All adjustments may be computed on a statewide basis, although some (e.g. reinsurance, stop/loss) may be specific to certain contracts and should be noted where appropriate. Similarly, some adjustments will apply to all services and to all eligibility categories while others will only apply to specific services provided to distinct eligibility categories. Again, it is very important to complete this preprint and Appendices D.III and D.IV as necessary to account for the proper methodology used by the State to calculate the UPL.

Describe below the methodology used to develop each adjustment. Prior approval is necessary for methodologies that are not listed as an optional check-off. Please note on each adjustment if the methodology is proprietary to the actuary. Note: HCFA's intent is that if an accepted methodology is used (i.e., is one of the check-offs) and the size of the adjustment is noted in the Appendices and appears reasonable, then no additional documentation would be required for the waiver application. However, the HCFA RO may require more documentation during the UPL and contract rate approval process.

Please note the waiver years that each adjustment was in place if the adjustment was not made for all four years. Submit separate Appendix D.IV charts for each year in the Without Waiver costs for the previous and upcoming waiver period.

Previous Waiver Period

a. _N/A_ During the last waiver period, the methodology used to calculate cost-effectiveness was different than described in the waiver governing that period. The differences were:

Please note the date of any methodology change and explain any methodology changes in this preprint. See also Step 5.

Upcoming Waiver Period -- For all three subsets of adjustments (Without Waiver Response required, Optional, and With Waiver Cost Adjustments) in this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response.

State Response to These Adjustments Is Required

a. Disproportionate Share Hospital (DSH) Payments: Section 4721 of the BBA specifies that DSH payments must be made solely to hospitals and not to MCOs/PHPs. Therefore, DSH payments are not to be included in cost-effectiveness calculations. Section 4721(c) does permit an exemption to the direct DSH payment. If this exemption applies to the State, please identify and describe in the Other Block.

1._X_ We assure HCFA that DSH payments are excluded from base year data.
2._X_ We assure HCFA that DSH payments are excluded from adjustments.
3.___ Other (please describe):

b. Incurred but not Reported (IBNR) (Appendix D.III, Line 47): Due to the lag between dates of service and dates of payment, completion factors must be applied to data to ensure that the base data represents all claims incurred during the base year. The IBNR factor increases the reported totals to an estimate of their ultimate value after all claims have been reported. Use of at least three years is recommended as a basis.

Basis:

1._X_ IBNR adjustment was made. Please indicate the number of years used as basis __3_____.
   i._X_ Claims in base year data source are based on date of service.
   ii.___ Claims in base year data source are based on date of payment.

2.___ IBNR adjustment was not necessary (Please explain).

Methodology:

1._X_ Calculate average monthly completion factors and apply to the known paid total to derive an overall completion percentage for the base period.
2.___ Other (please describe):

c. Inflation (Appendix D.III, Line 48): This adjustment reflects the expected inflation in the FFS program between the Base Year and Year One and

Two of the waiver. Inflation adjustments may be service-specific and expressed as percentage factors. States should use State historical FFS inflation rates.

Basis:

1. _X_ State historical inflation rates
   (a) Please indicate the years on which the rates are based: Inflation base years____3_____
   (b) Please indicate the mathematical methodology used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.):

2. ___ Other (please describe):

d. Third Party Liability(TPL) (Appendix D.III, Line 61): This adjustment should be used only if the State will not collect and keep TPL payments for post-pay recoveries. If the MCO/PHP will collect and keep TPL, then the Base Year costs should be reduced by the amount to be collected.

Basis and methodology:

1. ___ No adjustment was necessary
2. ___ Medicaid Management Information System (MMIS) claims tapes for UPL and rate development were cut with post-pay recoveries already deducted from the database.
3. ___ State collects TPL on behalf of MCO/PHP enrollees
4. ___ The State made this adjustment:
5. _X_ Post-pay recoveries were estimated and the base year costs were reduced by the amount of TPL to be collected by MCOs/PHPs.
6. ___ Other (please describe):

e. FQHC and RHC Cost-Settlement Adjustment (Appendix D.III, Line 46) : This adjustment accounts for the requirement of States to make supplemental payments for the difference between the rates paid by an MCO/PHP to an FQHC or RHC and the reasonable costs of the FQHC or RHC. The UPL and capitated rates should include payments for comparable non-FQHC or non-RHC primary care service expenditures.

1. ___ Cost-settlement supplemental payments made to FQHCs/RHCs are included in without waiver costs, but not included in the MCO/PHP rates, base year UPL costs, or adjustments. The State also accounted for any phase-down in FQHC/RHC payments beginning in Fiscal Year 2000, as outlined by Section 4712 of the BBA. If the State pays a percentage of cost-settlement different than outlined in the BBA not to exceed 100 percent, please list the percentage paid _____. The UPL and capitated rates should include payments for comparable non-FQHC or non-RHC primary care service expenditures.

2. _X_ Other (please describe): **Without waiver costs do not include supplemental and settlement payments to FQHCs and RHCs.**

f. Payments / Recoupments not Processed through MMIS (Appendix D.III, Line 51): Any payments or recoupments for covered Medicaid State Plan services included in the waiver but processed outside of the MMIS system should be included in the UPL.

1. _X_ Payments outside of the MMIS were made. Those payments include (please describe): **out-of-state providers, hospice services**
2. _X_ Recoupments outside of the MMIS were made. Those recoupments include (please describe): **paternity confinements**
3. ___ The State had no recoupments/payments outside of the MMIS.

g. Pharmacy Rebate Factor (Appendix D.III, Line 68): Rebates that States receive from drug manufacturers should be deducted from UPL base year costs if pharmacy services are included in the capitated base. If the base year costs are not reduced by the rebate factor, an inflated UPL may result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are under the waiver but not capitated.

Basis and Methodology:

1. _X_ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population.
2. ___ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS.
3. ___ Other (please describe):

Optional Adjustments

Note: These adjustments may be made based upon the State's own policy preferences. There is no HCFA preference for any of these adjustments. If the State has made an adjustment to its without waiver cost, information on the basis and methodology used is required and must be mathematically accounted for in Appendix D.IV. If the State has chosen not to make these adjustments, please mark the appropriate box.

a. Administrative Cost Calculation(Appendix D.III, Line 44): The administrative expense factor should include administrative costs that would have been attributed to members participating in the MCO/PHP if these members had been enrolled in FFS. Only those costs for which the State is no longer responsible should be recognized. Examples of these

costs include per claim claims processing costs, additional per record PRO review costs, and additional Surveillance and Utilization Review System (SURS) volume costs.

Basis:

1. _X_ All estimated administrative costs of the FFS plan that would be associated with enrolled managed care members if they had been enrolled in the FFS delivery system in this adjustment. This is equal to __**1.8**__ percent of FFS service costs.
2. ___ The State has chosen not to make adjustment.
3. ___ Other (please describe):

Methodology:

1. ___ Determine administrative costs on a PMPM basis by adding all FFS administrative costs and dividing by number of total Medicaid FFS members
2. ___ Determine the percentage of medical costs that are administrative and apply this percentage to each rate cell.
3. _X_ Other (please describe): **Historical administrative PMPM from period when fee-for-service was predominant service structure was used.**

b. Copayment Adjustment (Appendix D.III, Line 45): This adjustment accounts for any copayments that are collected under the FFS program but not to be collected in the capitated program. States must ensure that these co-payments are included in the UPL if not to be collected in the capitated program.

Basis and Methodology:

1. ___ Claims data used for UPL development already included co-payments and no adjustment was necessary.
2. _X_ State added estimated amounts of co-payments for these services in FFS that were not in the capitated program.
3. ___ The State has chosen not to make adjustment.
4. ___ Other (please describe):

c. Data Smoothing Calculations for Predictability (Appendix D.III, Line 65): Costs in rate cells are smoothed through a cost-neutral process to reduce distortions across cells and adjust rates toward the statewide average rate. These distortions are primarily the result of small populations, access problems in certain areas of the State, or extremely high cost catastrophic claims.

Basis and Methodology

1. ___ The State made this adjustment (please describe):

2. _X_ The State has chosen not to make adjustment.

d. Investment Income Factor (Appendix D.III, Line 50): This factor adjusts capitation rates and UPLs because FFS claims are paid after a service is provided while payments under managed care are made before the time of services.

1. _X_ Since payments are made earlier, the equivalent amount of payment is slightly less, because the earlier payments would generate investment income between the date of receipts and the date of claim payment. A small reduction to the UPL was made. Factors to take into account include payment lags by type of provider; advances to providers; and the timing of payments to prepaid plans, relative to when services are provided.
2. ___ The State has chosen not to make adjustment.
3. ___ Other (please describe):

e. PCCM case-management fee deduction (Appendix D.III, Line 52): When States transition from a PCCM program to a capitated program and use the PCCM claims data to create capitated UPLs, any management fees paid to the PCCM must be deducted from the UPL.

1. ___ PCCM claims data were used to create capitated UPLs and management fees were deducted. Please note: if the State chose to use PCCM claims data, then this adjustment is required.
2. _X_ This adjustment was not necessary because the State used MMIS claims exclusive of any PCCM case-management fees.
3. ___ Other (please describe):

f. Pooling for Catastrophic Claims (Appendix D.III, Line 53): This adjustment should be used if it is determined that a small number of catastrophic claims are distorting per capita costs in some rate cells and are not predictive of future utilization.

Methodology:

1. ___ The high cost cases' costs are removed from the rate cells and the per capita claim costs are distributed statewide across a relevant grouping of capitation payment cells. No costs are removed entirely from the rate cells, merely redistributed to rate cells in a manner that is more predictive of future utilization.
2. _X_ The State has chosen not to make adjustment.
3. ___ Other (please describe):

g. Pricing (Appendix D.III, Line 54): These adjustments account for changes in the cost of services under FFS. For example, changes in fee schedules, changes brought about by legal action, or changes brought about by legislation.

Basis:

1._X_ Expected State Medicaid FFS fee schedule increases between the base and rate periods.
2.___ The State has chosen not to make FFS price increases in the managed care rates.
3.___ Changes brought about by legal action (please describe):
4.___ Changes in legislation (please describe):
5.___ Other (please describe):

h. Programmatic/policy changes (Appendix D.III, Line 55): These adjustments should account for any FFS programmatic changes that are not cost neutral and affect the UPL. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program.

Basis and Methodology:

1.___ The State made this adjustment (please describe).
2._X_ The State has chosen not to make adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.

i. Regional Factors applied to Small Populations (Appendix D.III, Line 59): This adjustment is to be applied when there are a small number of eligible months in certain rate cells and large variations in PMPMs across these categories and regions exist.

Methodology:

1._X_ Regional factors based on eligible months are developed and then applied to statewide PMPM costs in rate cells for small populations. This technique smoothes out wide fluctuations in individual rate cells in rural states and some populations, yet ensures that expenditures remain budget neutral for each region and State.
2.___ The State has chosen not to make adjustment.
3.___ Other (please describe):

j. Retrospective Eligibility (Appendix D.III, Line 60): States that have allowed retrospective eligibility under FFS must ensure that the costs of providing retrospective eligibility are not included in the UPL. The rationale for this is that MCOs/PHPs will not incur costs associated with retrospective eligibility because capitated eligibility

is prospective. Please note, however, that newborns need not be removed from the base year costs if the State provides retrospective eligibility back to birth for newborns.
Basis and Methodology:

1.___ Compare the date that the enrollee was determined Medicaid-eligible by the State to the date at which Medicaid-eligibility became effective. If the effective date is earlier than the eligibility date, then the costs for retrospective eligibility were removed.

2.___ The State has chosen not to make adjustment because it was not necessary given the State's enrollment process.

3._X_ Other (please describe): **The state assigned an estimated number of months of retroactive eligibility by aid category. A claim adjustment was made based on claims in the earlier months.**

k. Utilization (Appendix D.III, Line 62): This adjustment reflects the changes in utilization of FFS services between the Base Year and the beginning of the waiver and between Years One and Two of the waiver.

1.___ The State estimated the changes in technology and/or practice patterns that would occur in FFS delivery, regardless of capitation. Utilization adjustments made were service-specific and expressed as percentage factors.

2._X_ The State has chosen not to make adjustment.

3.___ Other (please describe):

l. Other Adjustments including but not limited to guaranteed eligibility and risk-adjustment (Appendix D.III, Line 63). If the State enrolls persons with special health care needs, please explain by population any payment methodology adjustments made by the State for each population. For example, HCFA expects States to set rates for each eligibility category (i.e., the State should set UPLs and rates separately for TANF, SSI, and Foster Care Children). Please list and describe the basis and methodology:

Step 9: **With Waiver Cost Adjustments** (in addition to the Capitated or FFS Base Year Cost Adjustments), Appendix D.III, Lines 70-72). Note: Costs for the following adjustments are included in the With Waiver Costs Appendix D.V.

a. Reinsurance or Stop/Loss Coverage (Appendix D.III, Line 71): Please note whether or not the State will be providing reinsurance or stop/loss coverage. Reinsurance may be provided by States to MCOs/PHPs when MCOs/PHPs exceed certain payment thresholds for individual enrollees. Stop loss provisions usually set limits on maximum days of coverage or

number of services for which the MCO/PHP will be responsible. If the State plans to implement either reinsurance or stop/loss, a description of the methodology used is required. The State must document the probability of incurring costs in excess of the stop/loss level and the frequency of such occurrence based on FFS experience. The rate of expenses per capita should be deducted from the capitation year projected costs. In the initial application, the effect should be neutral. In the renewal report, the actual reinsurance cost and claims cost should be reported in with waiver costs.

Basis and Methodology:

1. _X_ The State does not provide reinsurance or stop/loss for MCOs/PHPs, but requires MCOs/PHP to purchase such coverage privately. No adjustment was necessary.
2. ___ The State provides reinsurance or stop/loss (please describe):

b. Incentive/bonus payments (Appendix D.III, Line 72): This adjustment should be applied if the State elects to provide incentive payments in addition to capitated payments under the waiver program. The State must document the criteria for awarding the incentive payments, the methodology for calculating incentives/bonuses, and the monitoring the State will have in place to ensure that total payments to the MCOs/PHPs do not exceed the UPL. The costs associated with any bonus arrangements must be accounted for in Appendix D.V With Waiver costs. Please describe the criteria for awarding incentive payments, the methodology for calculating bonus amounts, and the monitoring the State will have in place to ensure that total payments to MCOs/PHPs do not exceed the UPL: **For purposes of the cost effectiveness analysis, the incentive pool amounts are included in the rates.**
The Comprehensive Health Care Program contract between Medicaid Health Plans and the State establish a .0025 withhold of the approved capitation for each contractor. The amount withheld creates a fund for awarding health plan performance on an annual basis.

c. Other Adjustments (Please list and describe the basis and methodology):

IV. Without Waiver Development: Appendix D.IV

Purpose: To calculate without waiver costs on a PMPM basis.

NOTE: HCFA will measure the cost effectiveness of the waiver in the renewal based on this PMPM calculation and the actual enrollment under the waiver.

Please note that the data in this section for Waiver Years 1 and 2 should reflect the PMPM Without Waiver costs that were approved in the previous waiver in your renewal, plus any changes approved by the RO in the annual capitated rate approval. Please submit separate

Appendix D.IV charts for each year in the Without Waiver costs for the previous and upcoming waiver period.

Step 10: See instruction box.

Step 11: See instruction box. These rate cells must be identical to the rate cells used in Appendix D.II Member Months.

Steps 12-13: See instruction boxes.

Step 14: See instruction box. Adjustments expressed as percentages are applied to the base year amount by category of service.

Steps 15-16: See instruction boxes.

Step 17: See instruction box. Step 17 is designed to incorporate the cost of FFS wraparound services into the without waiver costs. To simplify presentation, the State may combine all wraparound services listed at Appendix D.III, presenting them as one base year amount per rate cell. The State may then combine all adjustment factors which affect a given rate cell, and apply the adjustments accordingly. This methodology will result in a subtotal of adjusted FFS costs applied to each rate cell. If the State prefers, individual FFS wraparound services may be calculated on Appendix D.IV, as illustrated with pharmacy services in the example (Columns Z-AF). If adjusted FFS costs are material, the State should be prepared to explain the adjustments upon request.

Step 18: See instruction box. These amounts represent the final PMPM amounts which will be applied to actual enrollment in measuring cost effectiveness. States will not be held accountable for caseload changes when submitting their waiver renewal cost-effectiveness calculations. States should have PMPM costs for the 2-year period equal to or less than projected Without Waiver costs as calculated in Step 18.

V. With Waiver Development: Appendix D.V

Steps 19-29

The actuarial basis for the capitation rates for both MCOs and PHPs must be specified in the waiver application, and there must be a demonstration that payments to the contractor will be on an actuarially sound basis, in accordance with the regulations at 42 CFR 434.61. The capitation rates must be specified in

the waiver application. Specifying the "actuarial basis" of the capitation rate means providing a description of the methodology the State uses to determine its capitation rate(s). Among the possible methods a State might use are: a percentage of the UPL; a budget-based rate (e.g., the MCO/PHP's cost); and the contractor's community rate with adjustments as appropriate (e.g., for the scope of services in the State's contract and the utilization characteristics of the Medicaid enrollees).

You may use other methods as well. If there are adjustments for stop-loss and reinsurance arrangements, the actuarial basis for these adjustments should be documented. The important things to remember are that the rate methodology must be specified and there must be a demonstration that the rates do not exceed the UPL.

Finally, as specified in 42 CFR 447.361, payments to contractors must be no more than the cost of providing those same services on a FFS basis, to an actuarially equivalent nonenrolled population group (i.e., no greater than the UPL).

With waiver costs are the sum of payments to capitated providers, FFS payments for managed care enrollees that are controlled or affected by managed care providers, and the costs to the State of implementing and maintaining the managed care program.

a. Please mark and complete the following assurances to HCFA:

1. _X_ The State assures HCFA that the capitated rates will be equal to or less than the UPL based upon the following methodology. Please attach a description of the rate setting methodology and how the State will ensure that rates are less than the UPL if the State is not setting rates at a percent of UPL.
   - (a)__ Rates are set at a percent of UPL
   - (b)_X Negotiation (please describe): **The state uses a competitive bid process.**
   - (c)__ Experience-based (contractor/State's cost experience or encounter data) (please describe):
   - (d)__ Adjusted Community Rate (please describe):
   - (e)__ Other (please describe):

2. _X_ The rates were set in an actuarially sound manner. Please list the name, organizational affiliation of the actuary used, and actuarial attestation of the initial capitation rates.
   Robert M. Damler, FSA, MAAA, Milliman USA, Inc.
   See Attachment FF, Actuarial Certification and Attestation

3._X_ The State will submit all capitated rates to the HCFA RO for prior approval.

b.___ The State is requesting a 1915(b)(3) waiver in section A.II.g.2 and will be providing non-state plan medical services.

1.___ The State will be spending a portion of its savings above the capitation rates for additional services under the waiver.

Please state the actual amounts spent on 1915(b)(3) savings that was spent on additional services in the previous waiver period_____. This amount must be built into the State's with waiver costs for Years 1 and 2.

Please state the PMPM or aggregate amount of 1915(b)(3) savings that will be spent on additional services in the upcoming waiver period_____. This amount must be built into the State's with waiver costs for Years 3 and 4.

2.___ The State is requiring plans to spend a portion of their capitated rate on additional non-State plan medical services.

Please state the actual amount or percent of the PMPM that was spent on average on non-State plan covered medical services_____. This amount must be built into the State's with waiver costs as a portion of the capitated rates. Please document the actual amount spent on non-State plan medical services.

Please estimate the amount or percent of the PMPMs that will be spent on average on non-State plan covered medical services_____. This amount must be built into the State's with waiver costs as a portion of the capitated rates. Please explain the assumptions that the State used to calculate this amount.

Steps 19-20: See instruction boxes. The eligibility categories and rate cells must agree with those in Appendix D.IV. States must document actual PMPM costs under the waiver for the previous two-year period. They also must estimate the PMPM costs under the upcoming waiver period. **Please note that the data in this section for Waiver Years 1 and 2 should reflect the actual costs incurred in the previous waiver period under the Waiver Program. Please submit**

separate Appendix D.IV charts for each year in the Without Waiver costs for the previous and upcoming waiver period. Note: because of the timing of the waiver renewal submittal, the State may need to estimate up to six (6) months of enrollment data for Year 2 of the previous waiver period.

Steps 21-29: See instruction boxes.

VI. Year 1 Aggregate Costs: Appendix D.VI
See Instructions for C.VII Year 2 Aggregate Costs

VII. Year 2 Aggregate Costs: **Appendix D.VII**
Steps 30-35: See instruction boxes.

VIII. Year 3 Aggregate Costs: **Appendix D.VIII**
See Instructions for C.VII Year 2 Aggregate Costs

IX. Year 4 Aggregate Costs: **Appendix D.IX**
See Instructions for C.VII Year 2 Aggregate Costs

X. Cost Effectiveness Summary: Appendix D.X
Steps 36-40: See instruction boxes.

Section E. Fraud and Abuse

States can promote the prevention, detection, and reporting of fraud and abuse in managed care by ensuring both the State and the MCOs/PHPs have certain provisions in place.

Previous Waiver Period

a. During the last waiver period, the program's fraud and abuse requirements operated differently than described in the waiver governing that period. The differences were:
During the last waiver period, **the DCH developed policy that resulted in the CHCP Contract Change to establish a new subsection, II-CC, (Responsibilities of the Department of Community Health for Medicaid Fraud and Abuse). This section required the MCOs to provide to DCH the following information when reporting suspected fraud and abuse**:

- **Nature of the Complaint**
- **The name of the individuals and/or entity involved in the suspected fraud and/or abuse, including their address, phone number and Medicaid identification number and any other identifying information.**

Further, the MCOs were directed to not attempt to investigate or resolve the reported suspicion, knowledge or action without informing the DCH and must cooperate fully in any investigation by the DCH or Office of Attorney General and any subsequent legal action that may result from such investigation. The Contract Change also included specific definitions of Abuse and Fraud.

Previous versions of the CHCP Contract contained more general instructions regarding Fraud/Abuse activities, required cooperation with state agencies, including Attorney General's Office.

b. Required for all elements checked in the previous waiver submittal] Please provide summary results from all fraud and abuse monitoring activities, including a summary of any analysis and corrective action taken, for the previous waiver period [items E.I-II of 1999 initial preprint; relevant sections of 1995 preprint].

The CHCP program has included in the on-site tool, (Attachment J), criteria related to various fraud and abuse issues in a managed care environment. Each annual site visit to contracting HMOs includes a review/assessment of compliance with the criteria. Attachment Q,

(summary of site visit reports) includes information regarding the overall performance of the CHCP Contracting HMOs in this area.

Upcoming Waiver Period -- Please check all items below that apply, and describe any other measures the State takes. For all items in this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response.

I. State Mechanisms

a. _X_ The State has systems to avoid duplicate payments (e.g., denial of claims for services which are the responsibility of the MCO/PHP, by the State's claims processing system).

b. _X_ The State has a system for reporting costs for non-capitation payments made in addition to capitation payments (e.g., where State offered reinsurance or a stop/loss limit results in FFS costs for enrollees exceeding specified limits)

c. _X_ The State has in place a formal plan for preventing, detecting, pursuing, and reporting fraud and abuse in the managed care program in this waiver, which identifies the staff, systems, and other resources devoted to this effort. Please attach the fraud and abuse plan. **The DCH has established a policy directive for the conduct of Fraud and Abuse oversight, including the development of "Managed Care Fraud and Abuse Staff Guidelines". (see Attachment W—MDCH Fraud/Abuse Guidelines)**

d. _X_ The State has a specific process for informing MCOs/PHPs of fraud and abuse requirements under this waiver. If so, please describe. **The MDCH has informed all MCOs of their obligations regarding fraud and abuse requirements. The MDCH has and will continue to utilize the formal annual site visit review to assess each MCOs internal structure for fraud and abuse detection and reporting. Further, MDCH staff will be conducting independent analysis from encounter data and other sources to determine if patterns of fraud and abuse are present. (See Attachment B, CHCP Contract, Section II-CC)**

e.___ Other (please describe):

II. MCO/PHP Fraud Provisions

a. _X_ The State requires MCOs/PHPs to have an internal plan for preventing, detecting, and pursuing fraud and abuse. Please describe any required fraud and abuse plan elements. **Under Section II-CC of the Contract, MCOs are to report any suspected fraud and abuse instance to the MDCH Program Investigations Section along with the nature of the complaint, and name and other information regarding providers or enrollees involved in potential fraud/abuse. Under the Site Review criteria used for the annual site visits, specific issues of policies and procedures are assessed against current practices to assure that each MCO operates their internal fraud/abuse policy consistent with the State Requirements.**

b. _X_ The State requires MCOs/PHPs to report suspected fraud and cooperate with State (including Medicaid Fraud Control Unit) investigations. **(See Attachment B, CHCP Contract, Section II-CC)**

Section F. Special Populations

States may wish to refer to the October 1998 HCFA document entitled "Key Approaches To The Use of Managed Care Systems For Persons With Special Health Care Needs" as guidance for efforts to ensure access and availability of services for persons with special needs. To a certain extent, key elements of that guide have been incorporated into this waiver application form.

I. General Provisions for Special Populations

Previous Waiver Period

a.__ During the last waiver period, the program operated differently for special populations than described in the waiver governing that period. The differences were:

b. _X_ [Required for all elements of applicable sections checked in the previous waiver submittal] Please provide results from all monitoring efforts for each subpopulation noted in the previous waiver, including a summary of any analysis and corrective action taken, to determine the level of compliance with State requirements in the area of special populations for the previous waiver period [items F.I.a-g of the 1999 initial preprint; as applicable in 1995 preprint].

Under the current waiver, conditions were established by CMS to require specific reports and activities for Children with Special Health Care Needs as a special population group. The CHCP Program has operated under a principle that Children with Special Health Needs are served under a separate program administered in Michigan: Childrens Special Health Care Services, CSHCS which currently serves about 25,000 members. The terms of the CHCP Contract stipulate that any beneficiary that is enrolled in the CSHCS program is not eligible for the CHCP program and will be disenrolled. Approximately 2,200 beneficiaries are annually disenrolled from the CHCP program and prospectively enrolled in the CSHCS program based on identification of medical conditions by the CHCP Contracting HMOs. To accomplish these transfers from the CHCP Program to CSHCS, the MDCH staff (CSHCS and CHCP Programs) is provided with very specific reports on beneficiary health conditions. These reports contain medical eligibility, communication with parents or guardians regarding options for programs, and provider communication regarding continuity of care issues pre/post enrollment. (See Attachment V, administrative letter on CSHCS disenrollment).

Because of the waiver conditions imposed by CMS regarding other categories of children who may be of high health needs that are not generally included in the CSHCS program, (adoptive children and SSI Children) reports have been prepared and submitted to CMS. Specific monitoring has taken place regarding complaint/grievances and disenrollments for this remaining population and reports files with CMS.

c. _X_ Please describe the transition plan for situations where an enrollee with special health care needs will be assigned to a new provider when the current provider is not included in the provider network under the waiver. **The transition plan is generally an event that takes place from a transition from the CHCP program to the CSHCS program as described above. In those instances, the medical documentation is provided to the DCH to validate medical eligibility. Further, contact is made with parent and guardian to provide a choice—which is to continue with the CHCP program or to enroll in CSHCS (either FFS or Special Health Plan). If the choice is to switch to CSHCS then the Contracting HMO will provide all available information and the CSHCS program will assume responsibility. When the option is FFS, then only providers enrolled in the Medicaid program and CSHCS can participate. When the option is the Special Health Plan, then the provider network may extend beyond the Medicaid provider list and is often also included on CHCP Contracting HMOs.**

Within a Contracting HMO environment, Primary care provider selection is available to each enrolled beneficiary. If the preferred provider is not available, then the beneficiary may seek disenrollment from that HMO. Since some specialists prefer to work out-of-network, a preference for out-of-network care may be arranged by the HMO. It is assumed that the member will take advantage of the enrollment process and secure provider information regarding each participating HMO. Further, each beneficiary may disenroll without cause within 90 days of enrollment into an HMO. These provisions were inserted to minimize the provider selection issues faced by beneficiaries and still hold HMOs accountable for the delivery of all medically necessary services.

Upcoming Waiver Period -- For items a. through g. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your

response. Please check all items that apply to the State.
The upcoming waiver does not contain changes from the prior waiver. The CHCP Contract is structured to serve eligible Medicaid recipients through a managed care approach for the delivery of health care services with the focus on quality of care, accessibility, and cost effectiveness. The CHCP Program holds HMOs responsible for the delivery of all medically necessary services. It is expected that the Contracting HMOs will provide care coordination and individual case management services for each member requiring such services following assessment by their primary care provider.

a. _X_ The State has a specific definition of "special populations" or "populations with special health care needs." The definition should include populations beyond those who are SSI or SSI-related, if appropriate, such as persons with serious and persistent mental illness, and should specify whether they include adults and/or children. Some examples include: Children with special needs due to physical and/ or mental illnesses, Older adults (over 65), Foster care children, Homeless individuals, Individuals with serious and persistent mental illness and/or substance abuse, Non-elderly adults who are disabled or chronically ill with developmental or physical disability, or other. Please describe.
The CHCP Program requires MCOs to take into consideration the requirements of the Medicaid program and how to best serve the Medicaid population. It is recognized that special needs will vary by individual and by county and region. MCOs are required to have the capacity to respond to requests for assignment of specialists as Primary Care Providers, assist in coordinating with other support services, and generally respond and anticipate needs of the Enrollees with special needs. Michigan has also updated its CHCP Contract to allow the use of clinics as primary care providers to further extend the reach of health care services to beneficiaries.

b.___ There are special populations included in this waiver program. Please list the populations.

c. _X_ The State has developed and implemented processes to collaborate and coordinate with, on an ongoing basis, agencies, which serve special needs clients, advocates for special needs populations, special needs beneficiaries and their families. If checked, please briefly describe.
In addition to the response provided in the November 2001 CMS visit, the State conducted the following:

- **Participated in a Robert Wood Johnson grant project to support the transition of adult Medicaid beneficiaries with disabilities into**

managed care. A key element of the project was collaboration between local Centers for Independent Living (CILs) and Contracting HMOs via three components:

- **Consumer competency and education**
- **CIL/Provider interface (strengthening health plan capacities for serving persons with disabilities)**
- **Healthcare advocacy (building consumer-oriented advocacy networks)**

- **Our collaboration continues with the agencies serving persons with physical or mental disabilities such as**:
- **Michigan Association of Centers for Independent Living (MACIL)**
- **Michigan Disability Rights Coalition**
- **Michigan Rehabilitation Services**
- **Michigan Department of Career Development**

The enrollment services contractor, Michigan ENROLLS, provides on-going education and outreach to community agencies and encourages referral of special populations to call the Michigan ENROLLS call center or use field enrollment counselors. Michigan Enrolls also refers beneficiaries to the following agencies as appropriate and in some cases contact the agency and request that the agency contact the beneficiary:

- **DCH mental health and substance abuse central office staff**
- **Local Family Independence Agency offices**
- **Local health departments**
- **Local Community Health Services Programs**
- **Parent Participation Line for Children's Special Health Care Services (CSHCS)**

The enrollment services counselors are given education on various special populations, such as CSHCS, recipient monitoring, mental health and substance abuse, and foster care. In talking with the beneficiary, the counselor can determine whether a direct referral is necessary or if a referral should be made to DCH for follow up.

d. The State has programs/services in place, which coordinate and offer additional resources and processes to ensure coordination of care among:

1. _X_ Other systems of care (Please specify, e.g. Medicare, HRSA Title V grants, Ryan White CARE Act, SAMHSA Mental Health and Substance Abuse Block Grant Funds)
2. _X_ State/local funding sources
3. ___ Other (please describe):

e. _X_ The State has in place a process for ongoing monitoring of its listed special populations by special needs subpopulation included in the waiver in the following areas:

1.___ Access to services (please describe):
2.___ Quality of Care (please describe):
3.___ Coordination of care (please describe):
4.___ Enrollee satisfaction (please describe):
5._X_ Other (please describe):

The CHCP program administers the monitoring, assessment of quality of care, coordination of care and determination of enrollee satisfaction based on overall program objectives. The CHCP Contract is structured to serve eligible Medicaid recipients through a managed care approach for the delivery of health care services with the focus on quality of care, accessibility, and cost effectiveness. The CHCP Program holds HMOs responsible for the delivery of all medically necessary services. It is expected that the Contracting HMOs will provide care coordination and individual case management services for each member requiring such services following assessment by their primary care provider.

The CHCP Program requires MCOs to take into consideration the requirements of the Medicaid program and how to best serve the Medicaid population. It is recognized that special needs will vary by individual and by county and region. MCOs are required to have the capacity to respond to requests for assignment of specialists as Primary Care Providers, assist in coordinating with other support services, and generally respond and anticipate needs of the Enrollees with special needs. Michigan has also updated its CHCP Contract to allow the use of clinics as primary care providers to further extend the reach of health care services to beneficiaries.

The CHCP Program will provide required information if it becomes necessary to produce reports to CMS regarding the impact on certain population groups.

The monitoring of the MCOs for compliance with these requirements is done through the onsite review activity. Michigan has also added a criterion (4.10) to address the directives by CMS to Medical Directors regarding the monitoring of Children with Special Health Care Needs

(CSHCN). See Attachment J, CHCP Site Visit Survey Tool, Criteria 2.20, 2.12.4 and .5, 4.3.4 and 4.10.

f. X The State has standards or efforts under way regarding a location's physical Americans with Disabilities Act (ADA) access compliance for enrollees with physical disabilities. Please briefly describe these efforts, and how often compliance is monitored. OFIS onsite PCP visit.
The annual on-site visits, the on-site survey tool and the review by the Office of Financial and Insurance Services all provide to the State monitoring capabilities to assure health plan compliance with the Americans with Disabilities Act.

g. ___ The State has specific performance measures and performance improvement projects for their populations with special health care needs. Please identify the measures and improvement projects by each population. Please list or attach the standard performance measures and performance improvement projects:

II. State Requirements for MCOs/PHPs

Previous Waiver Period

a. ___ During the last waiver period, the program operated differently for special populations than described in the waiver governing that period. The differences were:

b. X [Required for all elements checked in the previous waiver submittal] Please provide results from all monitoring efforts for each subpopulation noted in the previous waiver, including a summary of any analysis and corrective action taken, to determine the level of compliance with State requirements in the area of special populations for the previous waiver period [items F.II.a-h of the 1999 initial preprint; as applicable in 1995 preprint].
Under the current waiver, conditions were established by CMS to require specific reports and activities for Children with Special Health Care Needs as a special population group. The CHCP Program has operated under a principle that Children with Special Health Needs are served under a separate program administered in Michigan: Children's Special Health Care Services, CSHCS which currently serves about 25,000 members. The terms of the CHCP Contract stipulate that any beneficiary that is enrolled in the CSHCS program is not eligible for the CHCP program and will be disenrolled. Approximately 2,200 beneficiaries are annually disenrolled from the CHCP program and prospectively enrolled in the CSHCS program based on identification of medical conditions

by the CHCP Contracting HMOs. To accomplish these transfers from CHCP Program to CSHCS, the DCH staff (CSHCS and CHCP Programs) is provided with very specific reports on beneficiary health conditions to determine medical eligibility, communication with parents or guardian regarding options for programs, and provider communication regarding continuity of care issues pre/post enrollment. (See Attachment V, administrative letter on CSHCS disenrollment).

Because of the waiver conditions imposed by CMS regarding other categories of children who may be of high health needs that are not generally included in the CSHCS program, (adoptive children and SSI Children) reports have been prepared and submitted to CMS. Specific monitoring has taken place regarding complaint/grievances and disenrollments for this remaining population and reports files with CMS. (See Attachment AA, Waiver Condition Reports).

Upcoming Waiver Period For items a. through h. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Please check all the items which apply to the State or MCO/PHP.

a. X The State has required care coordination/case management services the MCO/PHP shall provide for individuals with special health care needs. Please describe by population. **The CHCP Contract requires HMOs to take into consideration the requirements of the Medicaid program and how to best serve the Medicaid Population enrolled in the CHCP Program. The MCO is expected to stress the collaboration effort of both the State and private sector to operate a managed care system that meets the special needs of enrollees. (Attachment B, CHCP Contract, Section II-B-1)**

The same section of the CHCP Contract further requires the MCO to recognize that special needs will vary by individual and by county and region. Therefore, the MCO must have an underlying organizational capacity to address the special needs of their enrollees, such as responding to request for assignments of specialist as PCPs, assisting in coordinating with other support services, and generally responding and anticipating needs of enrollees with special needs.

b. X As part of its criteria for contracting with an MCO/PHP, the State assesses the MCO/PHP's skill and experience level in accommodating people with special needs. Please describe by

population. **The CHCP Program does not separate the requirements by population. Rather, the CHCP Contract requires the Contracting HMOs to provide all medically necessary services for each beneficiary. Further, the MCO is required to demonstrate that they have the capacity through network and out-of-network arrangements to provide such services.**

c. _X_ The State requires MCOs/PHPs to either contract or create arrangements with providers who have traditionally served people with special needs, for example, Ryan White providers and agencies which provide care to homeless individuals. If checked, please describe by population. **The CHCP Contract provides flexibility for these circumstances. As an example, the MCO must allow a specialist to perform as a PCP when the enrollee's medical condition warrants management by a physician specialist. The need for physician specialist should be determined on a case-by-case basis in consultation with the Enrollee. The CHCP Contract also requires the MCO to accept out-of-network arrangements for certain services, including family planning.**

Another example of these arrangements was the assurance that the Contracting HMOs would have services provided to members with HIV/AIDS by providers who meet the definition of "Experienced HIV/AIDS Provider". This requirement was facilitated through letters of attestation from all Contracting HMOs. (See Attachment BB, HIV/AIDS Attestation Memo).

d. _X_ The State has provisions in contracts with MCOs/PHPs which allow beneficiaries who utilize specialists frequently for their health care to be allowed to maintain these types of specialists as PCPs. If **not** checked, please explain by population. **The CHCP Contract permits the use of specialist as a PCP. See response above.**

e.___ The State collects or requires MCOs/PHPs to collect population-specific data for special populations. Please describe by population.

f.___ The State requires MCOs/PHPs that enroll people with special health care needs to provide special services, have unique medical necessity definitions and/or have unique service authorization policies and procedures.

1. Please note any services marked in the table in Section A.III.d.1 that are for special needs populations only by population.

2. Please note for Section C.II.b any unique definitions of "medically necessary services" for special needs populations by population.

3. Please note for Section C.II.d any unique written policies and procedures for service authorizations for special needs populations by population. For example, are MCOs required to coordinate referrals and authorizations of services with the State's Title V agency for any special needs children who qualify for Title V assistance.

g. _X_ The State requires MCOs/PHPs to identify individuals with complex or serious medical conditions in the following ways:

1. _X_ An initial and/or ongoing assessment of those conditions
2. ___ The identification of medical procedures to address and/or monitor the conditions.
3. ___ A treatment plan appropriate to those conditions that specifies an adequate number of direct access visits to specialists to accommodate implementation of the treatment plan.
4. _X_ Other (please describe):

The CHCP Contract requires HMOs to take into consideration the requirements of the Medicaid program and how to best serve the Medicaid Population enrolled in the CHCP Program. The MCO is expected to stress the collaboration effort of both the State and private sector to operation a managed care system that meets the special needs of enrollees. (Attachment B, CHCP Contract, Section II-B-1)

The same section of the CHCP Contract further requires the MCO to recognize that special needs will vary by individual and by county and region. Therefore, the MCO must have an underlying organizational capacity to address the special needs of their enrollees, such as responding to request for assignments of specialist as PCPs, assisting in coordinating with other support services, and generally responding and

anticipating needs of enrollees with special needs.

h.___ The State specifies requirements of the MCO/PHPs for the special populations in the waiver that differ from those requirements described in previous sections and earlier in this section of the application. Please describe by population.

Addendum to Section F:
Draft Interim Review Criteria for Children with Special Needs from June 4, 1999

This addendum is required if the State mandatorily enrolls children with special needs in any of these five subsets:

1. Blind/Disabled Children and Related Populations (eligible for SSI under title XVI);
2. Eligible under section 1902(e)(3) of the Social Security Act;
3. In foster care or other out-of-home placement;
4. Receiving foster care or adoption assistance; or
5. Receiving services through a family-centered, community-based coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, as is defined by the State in terms of either program participant or special health care needs.

When addressing these criteria in your written descriptions, please provide the following information by each appropriate subset of children with special needs:

- The State's responsibilities in managed care programs enrolling children with special needs.
- The State's requirements for MCOs/PHPs enrolling children with special health care needs.
- How the State monitors its own actions and that of its contracting MCOs and PHPs.
- For foster-care children only, the provisions that address the broader, unique issues occurring because of out-of-home, out-of-geographic area placement.

I. State Responsibilities for Managed Care Programs Enrolling Children with Special Needs

a. _X_ Public Process [Required if the State mandatorily enrolls any of the children with special needs listed above] The State has in place a public process for the involvement of relevant parties (e.g., advocates, providers, consumer groups) during the development of the waiver program and has sought their participation in that process. Please describe *(Your description may refer to your waiver responses in Section A.I)*. **The CHCP Program's involvement with Stakeholders is described in the response to Section A.1 of this Waiver Renewal. As is noted elsewhere, the CHCP program includes the mandatory enrollment of two categories of those listed in this section: Children eligible for SSI and children receiving adoption assistance. All other categories are exempt from enrollment in the CHCP Program.**

b.___ Definition of Children with Special Needs [Required if the State mandatorily enrolls any of the children with special needs listed above] The State has a definition of children with special needs that includes at least these five subsets:

1.___ Blind/Disabled Children and Related Populations (eligible for SSI under title XVI);
2.___ Eligible under section 1902(e)(3) of the Social Security Act;
3.___ In foster care or other out-of-home placement;
4.___ Receiving foster care or adoption assistance; or
5.___ Receiving services through a family-centered, community-based coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, as is defined by the State in terms of either program participant or special health care needs.
6._X_ Other (please describe – *your description may refer to your description in Section F.I.a*). **. The CHCP Program has operated under a principle that Children with Special Health Needs are served under a separate program administered in Michigan: Children's Special Health Care Services, CSHCS which currently serves about 25,000 members. The terms of the CHCP Contract stipulate that any beneficiary that is enrolled in the CSHCS program is not eligible for the CHCP program and will be disenrolled. Approximately 2,200 beneficiaries are annually disenrolled from the CHCP program and prospectively enrolled in the CSHCS program based on identification of medical conditions by the CHCP Contracting HMOs. To accomplish these transfers from CHCP Program to CSHCS, the MDCH staff (CSHCS and CHCP Programs) is provided with very specific reports on beneficiary health conditions to determine medical eligibility, communication with parents or guardian regarding options for programs, and provider communication regarding continuity of care issues pre/post enrollment. (See Attachment V, administrative letter on CSHCS disenrollment).**

Because of the current waiver conditions imposed by CMS regarding other categories of children who may be of high health needs that are not generally included in the CSHCS program, (adoptive children and SSI Children) <u>reports have been prepared and submitted to CMS</u>. Specific monitoring has taken place regarding complaint/grievances and disenrollments for this remaining population and reports files with CMS. (See Attachment AA, Waiver Condition Reports

The CHCP Program does not separate the requirements by population. Rather, the CHCP Contract requires the Contracting HMOs to provide all medically necessary services for each beneficiary. Further, the MCO is required to demonstrate that they have the capacity through network and out-of-network arrangements to provide such services.

c. _X_ Identification [Required if the State mandatorily enrolls any of the children with special needs listed above] The State identifies and/or requires MCOs/PHPs to identify children with special needs. The State collects, or requires MCOs/PHPs to collect specific data on children with special needs. The State explains the processes it has for identifying each of the special needs groups described above. Please describe. **Under the waiver conditions, the CHCP Program was required to identify the Children defined as high health needs (SSI and Adoption Children) and provide this information as part of the enrollment data to Contracting HMOs. This has been provided and continues to be provided on a monthly basis as part of the enrollment tapes distributed to Contracting HMOs.**

d. ___ Enrollment/Disenrollment [Required if the State mandatorily enrolls any of the children with special needs listed above] The State performs functions in the enrollment/disenrollment process for children with special needs, including:

1. _X_ [Required if the State mandatorily enrolls any of the children with special needs listed above] Outreach activities to reach potential children with special needs and their families, providers, and other interested parties regarding the managed care program. Please describe *(Your description may refer to your response in Section A.III.b.1)*. **Enrollment Counseling will be provided by MICHIGAN ENROLLS through telephone access, face-to-face meetings and via information distributed in the mail. MICHIGAN ENROLLS holds subcontracts with local agencies that provide both information sessions as well as opportunities for individual counseling. All counselors hired by Maximus, (dba MICHIGAN ENROLLS) are given initial training that addresses the special needs of the Medicaid population, such as referral to community mental health agencies and other local agencies that provide services for that population. They also have desk references that will provide the information in writing that can be referred to after training is completed. The MICHIGAN ENROLLS maintains a dedicated TTY phone line for hearing impaired. The field staff**

is also provided with the same training as the call center staff. The regional coordinators, who oversee the field staff, are also available to provide assistance for beneficiaries and their families in accessing necessary services, coordinating with local agencies and in assuring such services are available within the MCO choices for new enrollees.

2. _X_ [Required if the State mandatorily enrolls any of the children with special needs listed above] Enrollment selection counselors have information and training to assist special populations and children with special health care needs in selecting appropriate MCO/PHPs and providers based on their medical needs. Please describe *(Your description may refer to your response in Section A.III.b.4.b)*. **See Response above**

3. _X_ [Required if the State mandatorily enrolls any of the children with special needs listed above] Auto-assignment process assigns children with special health care needs to an MCO/PHP that includes their current provider or to an MCO/PHP that is capable of serving their particular needs. Please describe *(Your description may refer to your response in Section A.III.b.4.g)*. **The algorithm for auto assignments does not distinguish the subpopulations and providers who may be used from the general population served by the Contracting HMOs. The Contracting HMOs must have the underlying provider base through network and out-of-network arrangements to provide all of the medically necessary services for each beneficiary enrolled.**

4. _X_ [Required if the State mandatorily enrolls any of the children with special needs listed above] A child with special needs can disenroll and re-enroll in another MCO/PHP for good cause. Please describe *(Your description may refer to your response in Section A.III.b.5.d.iii)*. **The CHCP Contract provides that any beneficiary may disenroll for cause—and may also disenroll any time within the first 90 days of new enrollment with any Contracting HMO. (See Attachment B, Section II-G-13).**

5. _X_ [Required if the State mandatorily enrolls any of the children with special needs listed above] If an MCO/PHP requests to disenroll or transfer enrollment of an enrollee to another plan, the reasons for reassignment are not discriminatory in any way -- including adverse change in an enrollee's health status and non-compliant behavior for individuals with mental health and substance abuse diagnoses -- against the enrollee. Please describe *(Your description may refer to your response in Section A.III.b.6.a)*. **The CHCP Contract**

provides that the MCO may not use the beneficiaries health care utilization patterns as a basis for disenrollment, (Attachment B, CHCP Contract, Section II-T-1).

e. _X_ Provider Capacity [Required if the State mandatorily enrolls any of the children with special needs listed above] The State performs functions in the monitoring provider capacity for children with special needs, including:

1. _X_ [Required if the State mandatorily enrolls any of the children with special needs listed above] The State ensures that the MCOs/PHPs in a geographic area have sufficient experienced providers to serve the enrolled children with special needs (e.g., providers experienced in serving foster care children, children with mental health care needs, children with HIV/AIDS, etc.). Please describe *(Your description may include reference to portions of your response in Section B.III.)*. **The CHCP Contract requires the MCO to demonstrate that they have the underlying capacity to provide the medically necessary services through network and out-of-network arrangements. Children in Foster Care are exempt from managed care, children with mental health care needs are served largely by the Community Mental Health Service Providers (CMHSPs).**

2. _X_ [Required if the State mandatorily enrolls any of the children with special needs listed above]The State monitors experienced providers capacity. Please describe *(Your description may include reference to portions of your response in Section B.III.)*. **The CHCP Contract requires the MCO to demonstrate that they have the underlying capacity to provide the medically necessary services through network and out-of-network arrangements. At the time of the initial CHCP waiver, The MDCH monitored the number of providers who were participants in the previous PCCM program to determine how many were contracted providers with MCOs. That assessment indicated about 85% of providers under PCCM continued as a provider with one or more MCO. In 1997 there were 1,622 primary care physicians contracted with MCOs in Wayne, Oakland and Macomb counties. This is a ratio of 1 PCP for every 255 beneficiaries. In May of 2000, that number was 1,699 and a ratio of 1:215. In April of 2002, that number remains about the same, 1,681 and the ratio is 1:208. These are unduplicated numbers and would suggest that the implementation of the CHCP program has not had a negative impact on provider participation. Additionally, the number of providers listed in the Provider Files maintained by Michigan Enrolls is reviewed periodically to determine**

overall capacity for the State, by county, region and statewide. Comparisons are made to ratios used to establish health professional shortage areas. The most current statewide ratio is less than 1 PCP for every 100 members compared to 1:1500 which is the starting ratio used for shortage area, suggesting that capacity is more than adequate

f. _X_ Specialists [Required if the State mandatorily enrolls any of the children with special needs listed above] The State performs functions in the monitoring specialist capacity, including:

1. _X_ [Required if the State mandatorily enrolls any of the children with special needs listed above] The State has set capacity standards for specialists. Please describe *(Your description may refer to your response in Section B.III.c)*. **The CHCP Program does not have a specific standard for specialists. However, the CHCP Contract does require the MCO to provide reasonable access depending on the type of specialist or sub-specialist, (CHCP Contract, Section II-M-6-a). Further the Contract holds the MCO responsible for providing access to all appropriate providers, including qualified specialists for all medically necessary services, (CHCP Contract, Section II-B-3). The MCO is required to submit provider files to the State's Enrollment Services Contractor, MICHIGAN ENROLLS, that provides a description of the MCO's service network, including the specialty and hospital network and arrangements for provision of medically necessary non-contracted specialty care. The initial approval of a service area is the responsibility of the State Office of Financial and Insurance Services, OFIS. That review and approval is predicated on a demonstration that adequate capacity is available through both contracted and out-of-network arrangements. The CHCP program accepts the determination by OFIS and subsequently monitors network adequacy to assure that any changes in the network arrangements do not affect the ability of a beneficiary to obtain needed care.**

2. _X_ [Required if the State mandatorily enrolls any of the children with special needs listed above] The State monitors access to specialists. Please describe. *(Your description may refer to your responses in Section B.IV)*. **The MCO is required to implement a Quality Assessment and Performance Improvement Program, (CHCP Contract, Section II-P-1). Within this assessment, the MCO is expected to establish and implement their own access standards in such areas as appointment times for PCPs and**

Specialist. The CHCP program assesses the performance of the MCO in implementing their standards. Finally, the annual Consumer survey, required under the Contract, (CHPC Contract Section II-P-5) includes beneficiary responses regarding access to care, including that of specialist.

3. _X_ [Required if the State mandatorily enrolls any of the children with special needs listed above] The State has provisions in MCOs'/PHPs' contracts which allow children with special needs who utilize specialists frequently for their health care to be allowed to maintain these types of specialists as PCPs or be allowed direct access to specialists for the needed care. Please describe *(Your description may refer to your response in Section F.II.d)*. **Under the CHCP Contract, the MCO must allow a specialist to perform as a PCP when the enrollee's medical condition warrants management by a physician specialist. The need for physician specialist should be determined on a case-by-case basis in consultation with the Enrollee. (See Attachment B, CHCP Contract, Section II-M-6-i**

4. _X_ [Required if the State mandatorily enrolls any of the children with special needs listed above] The State requires particular specialist types to be included in the MCO/PHP network. If specialists types are not involved in the MCO/PHP network, arrangements are made for enrollees to access these services (for waiver covered services only). Please describe *(Your description may refer to your responses in Section B.III.c)*. **The CHCP Program requires the Contracting HMOs to have the underlying capacity to provide all medically necessary services through contracted (network) providers or arrangements with out-of-network providers.**

g._X__Coordination [Required if the State mandatorily enrolls any of the children with special needs listed above] The State performs functions in the monitoring coordination of care for children with special needs, including:

1. _X_ [Required if the State mandatorily enrolls any of the children with special needs listed above] The State requires an assessment of each child's needs and implementation of a treatment plan based on that assessment. Please describe *(Your description may refer to your response in Section F.II.g)*. **While the CHCP Contract does not specially address this issue, the CHCP Program has issued clarifying instructions to Contracting HMOs. These instructions provided the following guidance regarding how to conduct assessment for Children with Special Health Care Needs, CSHCN:**

- **Send assessment forms to parent/guardian; or**
- **Send a letter to parent/guardian asking them to contact member services if they are experiencing any access to care problem; or**
- **Inform the PCPs that have CSHCN members assigned, and request summary information from the PCP regarding access to care and referral issues.**

The guidance provided further information regarding treatment plans including, that the PCP may determine that the CSHCN member will need a specified number of visits to an identified specialist and therefore prior authorizations would not be necessary for each visit until the limit was reached. (See Attachment CC, Memo to HMOs on CSHCN).

2. _X_ [Required if the State mandatorily enrolls any of the children with special needs listed above] The State has required the MCOs/PHPs to provide case management services to children with special needs. Please describe *(Your description may refer to your response in Section F.II.a)*. **The CHCP Program requires the Contracting HMOs to have the underlying capacity to provide all medically necessary services through contracted (network) providers or arrangements with out-of-network providers. This would include case management services when appropriate. The guidance provided to Contracting HMOs (See Attachment CC) especially for Children with Special Health Care Needs assumes that CSHCN members are receiving case management services where appropriate.**

3. _X_ [Required if the State mandatorily enrolls any of the children with special needs listed above] The State has developed and implemented a process to collaborate and coordinate with agencies and advocates, which serve special needs children and their families. Please describe *(Your description may refer to your response in Sections A.I, A.III.b, C.VII.a.3, and F.I.c)*. **The CHCP Program has operated under a principle that Children with Special Health Needs are served under a separate program administered in Michigan: Children's Special Health Care Services, CSHCS which currently serves about 25,000 members. The terms of the CHCP Contract stipulate that any beneficiary that is enrolled in the CSHCS program is not eligible for the CHCP program and will be disenrolled. Therefore, the prime relationship is between the CSHCS program and various stakeholders. The CSHCS program has**

continue to provide extensive communication with parents/guardians, local public and private agencies and other interest groups regarding the CSHCS program. This is in addition to the meetings and information provided to stakeholders described earlier for the CHCP Program.

4. _X_ [Required if the State mandatorily enrolls any of the children with special needs listed above] The State has a process for coordination with other systems of care (for example, Medicare, HRSA Title V grants, Ryan White CARE Act, SAMHSA Mental Health and Substance Abuse Block Grant Funds) or State/local funding sources. Please describe *(Your description may refer to your response in Section F.I.d)*. **The CHCP Program requires the Contracting HMOs to have the underlying capacity to provide all medically necessary services through contracted (network) providers or arrangements with out-of-network providers. Under the CHCP Contract, coordination is required with local mental health agencies and recommended with local public health agencies. Further encouragement is included in the contract with other agencies that may be available in regions of the State. (See Attachment B, CHCP Contract, Section II-M-6).**

5. _X_ [Required if the State mandatorily enrolls any of the children with special needs listed above] The State requires the MCO/PHP to coordinate health care services for special needs children with: providers of mental health, substance abuse, local health department, transportation, home and community based waiver, developmental disabilities, and Title V services. Please describe *(Your description may refer to your response in Section B.V and Section B.VI)*. **See response above**.

h._X__Quality of Care Monitoring [Required if the State mandatorily enrolls any of the children with special needs listed above] The State performs functions in the quality of care monitoring for children with special needs, including:

1. _X_ [Required if the State mandatorily enrolls any of the children with special needs listed above] The State has some specific performance measures for children with special needs (for example, CAHPS for children with special needs, HEDIS measures stratified by special needs children, etc.). Please describe *(Your description may refer to your response in Section C.VII.b and Section F.I.g)*. **As indicated earlier in the waiver renewal package, the CHCP program has established several**

performance measures as part of the CHCP Contract. (These are listed in Attachment I.) The performance measures are to address several issues affecting child health, including well-child visits and immunization rates and will be based on HEDIS and encounter data for all members enrolled in the CHCP Program (that meet the continuous enrollment requirement). The performance measures are in addition to the HEDIS reporting requirements and EQR reporting. The CAHPS surveys conducted by the CHCP Program in collaboration with the Contracting HMOs included both adult and adolescent survey questions. For the latter, the parent/guardian is responsible for providing the response, including parent/guardians of Children with Special Health Needs. For calendar years 2002 and 2004, the Michigan Department of Community Health, with assistance from their NCQA certified vendor, NCS Pearson, will conduct a member satisfaction survey for all child beneficiaries enrolled in the Medicaid contracted HMOs and in FFS. The State will use the HEDIS/CAHPS 2.0H Child Survey tool containing the Children with Chronic Conditions (CCC) measurement set.

2. _X_ [Required if the State mandatorily enrolls any of the children with special needs listed above] The State has specific performance improvement projects that address issues for children with special health care needs. Please describe *(Your description may refer to your response in Section C.VII.d and Section F.I.g).* **The CHCP program has initiated several initiatives for improving immunization rates and well-child visits that have been described elsewhere in this waiver renewal package. The CHCP Contract also requires each Contracting HMO to develop their own annual improvement initiative based on their assessment of needs. Some of these initiatives will affect the issues of Children with Special Health Care Needs.**

i. _X__ BBA Safeguards [Required if the State mandatorily enrolls children with special needs listed above] To the extent appropriate, the State develops a payment methodology that accounts for special needs populations enrolled in capitated managed care. Please describe *(Your description may refer to your response in Section D.III.I)*. **The Capitation payments to the Contracting HMOs are based on approved rates established through a competitive bid process that includes attestation by actuary firms regarding financial soundness**. **The payment methodology is based on a rate matrix that has established different weights depending on the age, sex, and program codes of the enrolled population. Payment to MCOs is based on the actual**

enrollment. The methodology is described in the discussion regarding upper payment limit.

k. _X_ Plan Monitoring [Required if the State mandatorily enrolls any of the children with special needs listed above] The State performs functions in the monitoring of plans for children with special needs, including:

1. _X_ [Required if the State mandatorily enrolls any of the children with special needs listed above] The State has in place a process for monitoring children with special needs enrolled in MCOs/PHPs for access to services, quality of care, coordination of care, and enrollee satisfaction. Please describe *(Your description may refer to your response in Section F.I.e)*. **As described earlier in the waiver renewal package, the CHCP Program has established a number of processes to monitor access, quality of care, coordination and enrollee satisfaction. These processes include provider capacity monitoring, encounter data reporting, HEDIS reports, CAHPS surveys on satisfaction, and EQR reports. All of these were described in the Independent Assessment, (Attachment N). Because the processes are intended to be global, that is for all enrolled CHCP members of Contracting HMOs, specific subpopulations can be assessed when necessary.**

2. _X_ [Required if the State mandatorily enrolls any of the children with special needs listed above] The State has standards or efforts in place regarding MCOs'/PHPs' compliance with ADA access requirements for enrollees with physical disabilities. Please describe *(Your description may refer to your response in Section F.I.f)*. **As indicated earlier in this waiver renewal package, the CHCP program has established criteria for the assessment of Contracting HMO compliance with a number of standards, including ADA. This is assessed during the annual on site reviews and by the Office of Financial and Insurance Services, OFIS.**

3. _X_ [Required if the State mandatorily enrolls any of the children with special needs listed above] The State defines medical necessity for MCOs/PHPs and the State monitors the MCOs/PHPs to assure that it is applied by the MCOs/PHPs in their service authorizations. Please describe *(Your description may refer to your response in Section F.II.f)*. **The CHCP Contract, defines medical necessity, (Attachment B, Section II-H-1).**

Section G. Complaints, Grievances, and Fair Hearings

MCOs/PHPs are required to have an internal grievance procedure approved in writing by the State agency, providing for prompt resolution of issues, and assuring participation of individuals with authority to order corrective action. The procedure allows an enrollee or a provider on behalf of an enrollee to challenge the denial of coverage of, or payment for services as required by 1932(b)(4) of the Act.

States are required to provide Medicaid enrollees with access to the State fair hearing process as required under 42 CFR 431 Subpart E, including:

- informing Medicaid enrollees about their fair hearing rights in a manner that assures notice at the time of an action,
- ensuring that enrollees may request continuation of benefits during a course of treatment during an appeal or reinstatement of services if State takes action without the advance notice and as required in accordance with State Policy consistent with fair hearings. The State must also inform enrollees of the procedures by which benefits can be continued for reinstated, and
- other requirements for fair hearings found in Subpart E.

I. Definitions:

Previous Waiver Period

a.___ During the last waiver period, complaints and grievances were defined differently than described in the waiver governing that period. The differences were:

Upcoming Waiver Period -- Please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response.

a._X_ Please provide definitions used by the State for complaint, grievance, or appeal.

Complaint: A communication by an Enrollee or an Enrollee's representative to the MCO expressing an opinion about care or service provided by the MCO, or presenting an issue to the MCO with a request for relief that can be resolved informally. Complaints may be oral or written. (Attachment B, CHCP Contract, Section II-U)

Grievance: A written complaint on behalf of an Enrollee, submitted by an Enrollee or a person, including but not limited to, a physician authorized to act on behalf of the Enrollee(Attachment B, CHCP Contract, Section II-U)

b. X Please describe any special processes that the State has for persons with special needs.
The CHCP Program has developed printed member materials for Arabic and Hispanic Medicaid enrollees. New member material also provides instructions on how to obtain translation services in four other languages (Hmong, Creole, Vietnamese and Chinese). Contracting HMOs are required to include this information in their member handbooks and to provide translated copies for those members when more than 5% of the MCO's members speak another language. Because the CHCP program provides the option of accessing the Medicaid Fair Hearing process before the exhaustion of internal complaint/grievance process, the CHCP Program provides assistance for Medicaid members through a toll-free phone line to initiate issues for Fair Hearing.

II. State Requirements and State Monitoring Activities:

Previous Waiver Period

a.**X During the last waiver period, the grievance standards or State monitoring were different than described in the waiver governing that period. The differences were:
Response: Modifications in the timeframes by which a grievance should be processed. Because the Michigan Legislature redefined the internal Complaint/Grievance process for licensed HMOs and the CHCP program only contracts with licensed HMOs, the CHCP program deleted reference to specific contract requirements and have now referred to the state licensure requirements for development of complaint and grievance process and standards. The on-site annual reviews continue to assess the complaint/grievance logs, and the CHCP Contract continues to require the submission of semi-annual complaint and grievance reports.

b. X Required for all elements checked in the previous waiver submittal] Please provide results from the State's monitoring efforts, including a summary of any analysis and corrective action taken with respect to complaints, grievances and fair hearings for the previous waiver period [items G.II.a and G.II.b of the 1999 initial preprint; as applicable in 1995 preprint]. Also, please provide summary information on the types of complaints, grievances or fair hearings during the previous two-year period following this addendum. Please note how access and quality of care concerns were addressed in the State's Quality Improvement Strategy.
During the annual on-site visit, each Contracting HMO is reviewed on their complaint and grievance process in

accordance with the State Statute requirements, (PA 251 & 252) including time limitations and advising members of their right to a State fair hearing as stated in the contract, member handbook and Site Visit Tool. (See Attachment J, Site Visit Tool pp. 6-7 Section 3, Criterion 3.10 and 3.11.) If the Contracting HMO fails or receives an incomplete on either criterion, that information is contained within the Health Plan review documentation. (See Attachment Q, On Site Summary Report)

The CHCP Program has created a system to develop Beneficiary Contact Reports regarding individual contact a beneficiary makes with the DCH regarding managed care. These reports are reviewed internally and are shared quarterly with Contracting HMOs. These reports list each beneficiary's complaint categorized by 21 contact types for each Plan. They include the member and percent of contacts DCH has received. The reports are forwarded to the individual Health Plans to monitor their operations and determine their problem areas.

c.____Please mark any of the following that apply:

1. X A hotline was maintained which handles any type of inquiry, complaint, or problem.

2. X Following this section is a list or chart of the number and types of complaints and/or grievances handled during the waiver period.
As noted above, the CHCP Program established the Beneficiary Contact, (BPCT) system that currently contains >225,000 contacts in the two years since its inception. The BPCT produces 18 standard reports by provider, beneficiary, types, reasons or other inquiries.

3. X There is consumer involvement in the grievance process. Please describe. **Each Contracting HMO must comply with the licensure requirement that a governing body will include at least 1/3 of its members from the consumer class. The Governing body is responsible for approving all policies, procedures and reviewing operational processes as well as receiving periodic reports on member grievances**.

Upcoming Waiver Period -- For items a. and b. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Please check any State requirements and State monitoring activities in effect for MCO/PHP grievance processes.

a. Required Complaints, Grievances, and Fair Hearings Elements:

1. _X_ The State requires MCO/PHPs to have a written internal grievance procedure, providing for prompt resolution of issues and assuring participation of individuals in authority.

2. _X_ The MCO/PHP grievance process is approved by the State prior to its implementation.

3. _X_ An MCO/PHP enrollee can request a State fair hearing under the State's Fair Hearing process. Please explain how, under what circumstances (i.e., direct access or exhaustion), and when an enrollee can access the State Fair Hearing process.
An enrollee must be told of their right to an administrative hearing if dissatisfaction is expressed at any point during the rendering of medical treatment or when a service is terminated, suspended or denied. The MCO's grievance or complaint process may occur simultaneously with MDCH administrative hearing process. (Attachment B, CHCP Contract, Section II-U)

4. _X_ Enrollees are informed about their fair hearing rights at the time of Medicaid eligibility determination and at the time of any action as defined in 42 C.F.R. 431 Subpart E.
(Attachment B, CHCP Contract, section II-U, 2. and Attachment DD, Beneficiary Complaint/Grievance Contact Diagram)

5. _X_ The State ensures that enrollees may request continuation of benefits or reinstatement of services during a course of treatment during a fair hearing appeal. The State informs enrollees of the procedures by which benefits can be continued or reinstated. **The MDCH has instituted policies and communicated to Contracting HMOs that services will continue during fair hearing appeal. See also Attachment DD, Beneficiary Complaint/Grievance Contact Diagram.**

6. _X_ Enrollees are informed about their complaint, grievance, and fair hearing rights at the time of MCO/PHP enrollment and/or on a periodic basis thereafter. Please specify how and through what means enrollees are informed.
When a beneficiary becomes eligible for Medicaid they are provided with a brochure, "Rights and Responsibilities" which includes information about their Medicaid Fair Hearing rights. Additionally, the above information is included in the member handbook provided to the member upon enrollment with the MCO. (Attachment B, CHCP Contract, Section II-U)

b. Optional Complaints, Grievances, and Fair Hearings Elements:

1. _X_ The internal grievance procedure required by the State is characterized by the following (please check any of the following optional procedures that apply to the State's required grievance procedure):

(a) _X_ The MCO/PHP governing body approves the grievance procedure and is responsible for the effective operation of the grievance process.

(b) _X_ The governing body or its delegated grievance committee reviews and resolves complaints and grievances. If the State has any committee composition requirements please list_____N/A.

(c) _X_ Reviews requests for reconsideration of initial decisions not to provide or pay for a service.

(d) _X_ Specifies a time frame from the date of action for the enrollee to request a grievance resolution or fair hearing. Specify the time frame.
The beneficiary or authorized representative has 90 calendar days from the date of the written notice of a negative action to request a Medicaid Fair hearing. The written hearing request must be received by the Department within that 90-day period.

(e)_X_ Includes time frames for resolution of grievances for MCO/PHP grievances. Specify the time frame set by the State.

The final determination will be made in writing no later than 35 calendar days after the formal grievance is submitted in writing by the enrollee. This timing may be tolled for any period of time the enrollee is permitted to take under the grievance procedure and for a period of time that shall not exceed 10 business days if the plan has not received requested information from a health care facility or health professional.

(f)_X_ Establishes and maintains an expedited grievance review process for the following reasons: If a delay would …Specify the time frame set by the State for this process.

A determination will be made by the plan no later than 72 hours after receipt of an expedited grievance. Within 10 days after receipt of a determination, the enrollee may request a determination of the matter by an independent review organization.

(g)_X_ Permits enrollees to appear before MCO/PHP personnel responsible for resolving the grievance.

(h)_X_ Provides that, if the grievance decision is adverse to the enrollee, the grievance decision and any supporting documentation is forwarded to the State within a time frame specified by the State. Specify the time frame.

Appellants and Administrative Hearing Reviewers have the right to review case record and obtain copies of need documents and materials relevant to the hearing. Copies are to be sent at least seven days before the scheduled hearing..

(i)_X_ The MCO/PHP acknowledges receipt of each complaint and grievance when received and explains to the enrollee the process to be followed in resolving his or her issue. If the State has a time frame for MCOs/PHPs to acknowledge complaints and grievances, please specify:

(j)_X_ Gives enrollees assistance completing forms or other assistance necessary in filing complaints or grievances (or as complaints and grievances are being resolved).

(k)_X_ Conducts grievance resolution/hearings using impartial individuals not involved in previous levels of decision making.

(l)_X_ If the focus of the grievance is a denial based on lack of medical necessity, one of the reviewers is a physician with appropriate expertise in the field of medicine that encompasses the enrollee's condition or disease.

(m)_X_ Bases the MCO/PHP's decision on the record of the case.

(n)_X_ Notifies the enrollee in writing of the grievance decision and further opportunities for appeal, as well as the procedures available to challenge or appeal the decision.

(o)_X_ Upon request, provides enrollees and potential enrollees with aggregate information regarding the nature of enrollee complaints and grievances and their resolution.

(p)__ Sets time frames for the MCO/PHP to authorize or provide a service if decision is overturned or reversed through the grievance or fair hearing process. Specify the time frame____

(q)_X_ Informs the enrollee of any applicable mechanism for resolving the issue external to the MCOs/PHPs own processes.

(r)___ Determines whether the issue is to be resolved through the grievance process, the process for making initial determinations on coverage and payment, or the process for resolution of disputed initial determinations.

(s)___ Other (please explain):

2._X_ MCOs/PHPs maintain a log of all complaints and grievances and their resolution.

3._X__MCOs/PHPs send the State a summary of complaints and grievances on at least an annual basis.

4._X_ The State requires MCOs/PHPs to maintain, aggregate, and analyze information on the nature of issues raised by enrollees and on their resolution.

5.___ The State requires MCOs/PHPs to conduct in-depth reviews of providers or services identified through summary reports as having undesirable trends in complaints and grievances.

6._X_ The State and/or MCO/PHP have ombudsman programs to assist enrollees in the complaint, grievance, and fair hearing process.

7.___ Other (please specify):

Section H. Enrollee Information and Rights

This section describes the process for informing enrollees and potential enrollees receive about the waiver program, and protecting their rights once enrolled. The information in this section (e.g., enrollee handbooks, enrollment information, PCP choice materials) is considered to be marketing material because it is sent directly to enrollees. However, the traditional marketing materials (e.g., billboards, direct mail, television and radio advertising) are addressed above in Section A (see A.III.a).

I. Enrollee Information - Understandable to Enrollees:

Previous Waiver Period

a.___ During the last waiver period, the requirements for understandable enrollee information operated differently than described in the waiver governing that period. The differences were:

b._X_ [Required] Please provide copies of the brochure and informational materials explaining the program and how to enroll. **See Attachment D, Michigan Enrolls packets: Mandatory, Migrant and Pregnant versions.**

Upcoming Waiver Period -- This section describes how the State ensures information about the waiver program is understandable to enrollees and potential enrollees. Please check all the items that apply to the State or MCO/PHP. For all items in this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Items which are required have "[Required]" in front of them. Checking a required item affirms the State's intent to comply. If the State does not check a required item, please explain why.

a._X__[Required] The State will ensure that enrollee materials provided to enrollees by the State, the enrollment broker, and the MCO/PHP are clear and easily understandable.

b._X_ Enrollee materials will be translated into the languages listed below (If the State does not translate enrollee materials, please explain):

The CHCP Program has developed printed member materials for Arabic and Hispanic Medicaid enrollees. New member material also provides instructions on how to obtain translation services in four other languages (Hmong, Creole, Vietnamese and Chinese).

The State has chosen these languages because (check any that apply):

1. _X_ The languages comprise all prevalent languages in the MCO/PHP service area.
2. ___ The languages comprise all languages in the MCO/PHP service area spoken by approximately ___ percent or more of the population.
3. ___ Other (please explain):

c. ___ Program information is available and understandable to non-English speaking enrollees whose language needs are not met through the provision of translated material described above. Please describe.

d. _X_ [Required] Translation services are available to all enrollees, regardless of languages.

e. _X_ Every new enrollee will have access to a toll-free number to call for questions. Please note if the State requires TTY/TDD for those with hearing/speech impairments:

f. ___ The State requires MCO/PHP enrollee information materials to be translated into alternative formats for those with visual impairments.

II. Enrollee Information - Content:

Previous Waiver Period

a. ___ During the last waiver period, the enrollee information requirements operated differently than described in the waiver governing that period. The differences were:

Upcoming Waiver Period -- This section describes the types of information given to enrollees and potential enrollees. Please check all that apply. For all items in this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Items which are required have "[Required]" in front of them. Checking a required item affirms the State's intent to comply. If a required item is not check, please explain why.

a. Information provided by the State and/or its Enrollment Broker. The State and/or its enrollment broker provide the following information to enrollees and potential enrollees.

1.___ Every new enrollee will be given a brief in-person presentation describing how to appropriately access services under the managed care system and advising them of enrollees' rights and responsibilities

2._X_ An initial notification letter

3._X_ Informational materials describing how to appropriately access services under the managed care system and advising them of enrollees' rights and responsibilities.

4._X_ A form for enrollment in the waiver program and selection of a plan

5._X_ A list of plans serving the enrollee's geographical area

6._X_ Comparative information about plans

7._X_ Information on how to obtain counseling on choice of MCOs/PHPs

8._X_ Detailed provider network listings

9._X**_ A new Medicaid card which includes the plan's name and telephone number or a sticker noting the plan and/or PCP's name and telephone number to be attached to the original Medicaid card (please specify which method);
Currently, a new Medicaid card is distributed by the State on a monthly basis that includes the plan's name and telephone number. The DCH is assessing the feasibility of distributing a Medicaid Plastic Card when the beneficiary becomes eligible for Medicaid. The Card would be used electronically to determine current eligibility status by providers and other vendors, as well as enrollment status with Contracting HMOs. This will be in addition to the Member ID card that is required to be issued upon enrollment by the Contracting HMO. Until this assessment is completed, the DCH will continue to issue monthly ID cards.

10.__ A health risk assessment form to identify conditions requiring immediate attention.

11._X_Information concerning the availability of special services, expertise, and experience offered by MCO/PHPs and providers

12._X_[Required] Information explaining the grievance procedures and how to exercise due process rights and their fair hearing rights.

13._X_[Required for MCOs with lock-in periods] Information about their right to disenroll without cause the first 90 days of each enrollment period. (See A.III.b.5)

14._X_[Required for MCOs] Information on how to obtain services not covered by the MCO/PHP but covered under the State plan.

15._X_[Required for MCOs] For enrollees in lock-in period, notification 60 days prior to end of enrollment period of right to change MCOs/PHPs (See A.III.b.5)

16.__ Other items (please explain):

b. Information provided by the MCO/PHP The State requires the MCO/PHP to provide, written information on the following items to enrollees and potential enrolls. Unless otherwise noted, required items must be provided upon actual enrollment into the MCO/PHP (the BBA requires some information be provided only upon request). Please check all that apply.

1._X_ [MCOs required to provide upon request] Enrollee rights.

2._X_ [MCOs required to provide upon request] Enrollee responsibilities.

3._X_ [MCOs required to provide upon request] Names, locations, qualifications and availability of network providers, including information about which providers are accepting new Medicaid enrollees and any restrictions on enrollees' ability to select from among network providers.

4._X_ [MCOs required to provide upon request] Amount, duration and scope of all benefits (included and excluded).

5. _X_ [MCOs required to provide upon request] Physician incentive program, including (1) if the MCO has a PIP that covers referral services; (2) the type of incentive arrangement; (3) whether stop-loss protection is provided; and (4) a summary of survey results, if a survey is required.

6. _X_ [Required for MCOs] The MCO enrollee materials (either through the enrollee handbook, semi-annual or annual open enrollment materials, or by some other means) annually disclose to enrollees their right to adequate and timely information related to physician incentives.

7. _X_ [MCOs and PHPs required to provide upon request *and* upon enrollment] Information explaining the complaints and grievance procedures for resolving enrollee issues, including issues relating to authorization of, coverage of, or payment for services.

8. _X_ [Required for MCOs] Procedures for obtaining services, including authorization requirements.

9. _X_ [Required for MCOs] After-hours and emergency coverage. The State ensures enrollee access to emergency services by requiring the MCO to provide the following information to all enrollees [note: these items are required of MCOs only; however, please fill in if applicable for PHPs]:

   i. _X_ the right to use participating and non-participating providers

   ii. _X_ definition of emergency services

   iii. _X_ the prudent layperson definition of emergency medical condition

   iv. _X_ the prohibition on retrospective denials for services that meet the prudent layperson definitions (e.g., to treat what appeared to the enrollee to be an emergency medical condition at the time the enrollee presents at an emergency room)

   v. _X_ the right to access emergency services without prior authorization

10. _X_ [Required for MCOs] Procedures for obtaining non-covered or out-of-area services.

11. _X_ [Required for MCOs] Any special conditions or charges that may apply to obtaining services.

12. _X_ [Required for MCOs and PHPs] The right to obtain family planning services from any Medicaid-participating provider

13. _X_ [Required for MCOs] Policies on referrals for specialty care and other services not furnished by the enrollee's primary care provider.

14. _X_ [Required for MCOs] Charges to enrollees, if applicable.

15. _X_ [Required for MCOs] Procedures for changing primary care providers.

16. _X_ Procedures for obtaining mental health, substance abuse, and developmental disability services.

17. ___ Procedures for recommending changes in policies or services.

18. _X_ The covered service area.

19. _X_ Notification of termination or changes in benefits, services, service sites, or affiliated providers (if the enrollee is affected). Notices are provided in a timely manner.

20. ___ A description of new technology or new technology acceptance policies that are included as covered benefits.

21. _X_ Enrollees' right to obtain information about the MCO/PHP, including information standards, utilization control procedures and the financial condition of the organization.

22. ___ Other (please describe):

III. Enrollee Rights:

Previous Waiver Period

a.___ During the last waiver period, the requirements for enrollee rights operated differently than described in the waiver governing that period. The differences were:

Upcoming Waiver Period -- For items a. through n. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Please check any of the processes and procedures in the following list the State requires to ensure that contracting MCOs/PHPs protect enrollee rights. The State requires MCOs/PHPs to:

a. _X_ Have written policies with respect to enrollee rights.

b. _X_ Communicate policies to enrollees, staff and providers.

c. _X_ Monitor and promote compliance with their policies by staff and providers.

d. _X_ Ensure compliance with Federal and State laws affecting the rights of enrollees such as all Civil rights and anti-discrimination laws.

e. _X_ Implement procedures to ensure the confidentiality of health and medical records and of other information about enrollees.

f. _X_ Implement procedures to ensure that enrollees are not discriminated against in the delivery of medically necessary services.

g. _X_ Ensure that all services, both clinical and non-clinical, are accessible to all enrollees, including special populations.

h. _X_ Ensure that each enrollee may select his or her primary care provider from among those accepting new Medicaid enrollees.

i. _X_ Ensure that each enrollee has the right to refuse care from specific providers.

j. _X_ Have specific written policies and procedures that allow enrollees to have access to his or her medical records in accordance with applicable Federal and State laws.

k. _X_ Comply with requirements of Federal and State law with respect to advance directives.

l. _X_ Have specific written policies that allow enrollees to receive information on available treatment options or alternative courses of care, regardless of whether or not they are a covered benefit.

m. _X_ Allow direct access to specialists for beneficiaries with long-term or chronic care needs (e.g., severely and persistently mentally ill adults or severely emotionally disturbed children)

n.__ Other (please describe):

IV. Monitoring Compliance with Enrollee Information and Enrollee Rights

Previous Waiver Period

a.___ During the last waiver period, the State monitored compliance with enrollee information and rights differently than described in the waiver governing that period. The differences were:

b. _X_ [Required for all elements checked in the previous waiver submittal] Please include the results from monitoring MCO/PHP enrollee information and rights in the previous two year period, including a summary of any analysis and corrective action taken [items H.IV.a-d of 1999 initial preprint; item A.22 of 1995 preprint].
Upon initial enrollment a member handbook is distributed and updated annually along with any other marketing material. (See Attachment B, CHCP Contract, Sections II-G, and II-S) This requirement is monitored through the annual on-visit process. (See Attachment J, Site Visit Survey Tool and Attachment Q, on-site summary report).

Upcoming Waiver Period -- For items a. through d. of this section, please identify any responses that reflect a change in program from the previous waiver submittal(s) by placing two asterisks (i.e., "**") after your response. Please check any of the processes and procedures the State uses to monitor compliance with its requirements for enrollee information and rights.

a. _X_ The State tracks disenrollments and reasons for disenrollments or requires MCOs/PHPs to track disenrollments and reasons for disenrollments and to submit a summary to the State on at least an annual basis.

b. _X_ The State will approve enrollee information prior to its release by the MCO/PHP.

c. _X_ The State will monitor MCO/PHP enrollee materials for compliance in the following manner (please describe):
The CHCP Program reviews and approves the proposed activity before it is distributed to the market area. The CHCP

Program may impose monetary or restricted enrollment penalties if written DCH approval has not been given. See IV(b) above. See Attachment C Marketing and Incentives Administrative Letter.

d. _X_ The State will monitor the MCO/PHPs compliance with the enrollee rights provisions in the following manner (please describe): **See IV(b) above. The CHCP Program also coordinates review of compliance with the Office of Financial and Insurance Services who have similar statutory responsibilities and oversight for HMOs.**

Section I. Resource Guide

Below are references that provide information related to Medicaid managed care quality assessment and improvement efforts, and rate setting and risk adjustment methodologies:

Actuarial Research Corporation, Report prepared for the Department of Health and Human Services (DHHS)/the Health Care Financing Administration (HCFA), Capitation Rate Setting in Areas with Eroded Fee-For-Service Base Final Report, 1992.

Actuarial Research Corporation, Setting an Upper Payment Limit Where the Fee for Services Base is Inadequate: Final Report, 1992.

Alpha Center, Report produced for the Robert Wood Johnson Foundation, Risk Adjustment: A Special Report, 1997.

Ann Arbor Actuaries, Inc., Report prepared for DHSS/HCFA, A Review of Rate Setting Methods of Selected State Medicaid Agencies for Prepaid Health Plans, 1991.

Ann Arbor Actuaries, Inc., Report prepared for DHSS/HCFA, Actuarially Sound Rate Setting Methodologies, 1991.

Conference Report 105-217 to accompany H.R. 2015, the Balanced Budget Act of 1997, (Section 4705 and the regulations being developed to implement these requirements).

Foundation for Accountability (FACCT), Foundation for Accountability (FACCT) Guidebook for Performance Measurement Prototype Summary, 1995.

Independent Assessment Guide Document, Health Care Financing Administration, December, 1998.

Joint Commission for Accreditation of Healthcare Organizations, National Library of Health Care Indicators, 1997.

Massachusetts Medical Society, Quality of Care: Selections from The New England Journal of Medicine, 1997.

Mathematica Policy Research, Inc, The Quality Assurance Reform Initiative (QARI) Demonstration For Medicaid Managed Care: Final Evaluation Report, 1996.

MEDSTAT Group, Report prepared for U.S. DHHS/HCFA, A Guide for States: Collecting and Analyzing Medicaid Managed Care Data, 1997.

MEDSTAT Group, Report prepared for U.S. DHHS/HCFA, Survey of Key Performance Indicators, 1997.

Medicaid Management Institute of the American Public Welfare Associations, report prepared for DHHS/HCFA, Medicaid Primary Care Case Management Programs: Guide for Implementation and Quality Improvement, 1993.

Merlis, Mark for National Governor's Association (NGA), Medicaid Contracts with HMOs and Pre Paid Health Plans: A Handbook for State Managers, 1987. (**Rate Setting Description still applicable)

National Academy for State Health Policy, Quality Improvement Primer For Medicaid Managed Care, 1995.

National Academy for State Health Policy, Quality Improvement Standards and Processes Used by Select Public and Private Entities to Monitor Performance of Managed Care: A Summary, 1995.

National Academy for State Health Policy, Report prepared for HCFA, Quality Improvement System for Managed Care, 1997.

National Committee for Quality Assurance (NCQA), Health Plan Employer Data and Information Set (HEDIS © Current Version).

President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, Final report to the President of the United States, Quality First: Better Health Care for All Americans, 1998.

U.S. DHHS/HCFA, A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States, 1993.

U.S. DHHS/PHS/AHCPR, Conquest 1.1: A Computerized Needs-Oriented Quality Measurement Evaluation System, 1996.

U.S. DHHS/PHS/AHCPR, Consumer Assessment of Health Plans (CAHPS) Satisfaction Survey, 1997.

U.S. DHHS/PHS/AHCPR, Putting Research to Work in Quality Improvement and Quality Assurance: Summary Report, 1993, Publication No. 93-0034.

U.S. DHHS/PHS/AHCPR Research Activities Newsletter, Monthly publication.

U.S. DHHS/HCFA and National Committee on Quality Assurance (NCQA), Health Care Quality Improvement Studies in Managed Care Settings: Design and Assessment: A Guide for State Medicaid Agencies, 1994, Purchase Order #HCFA-92-1279.

U.S. DHHS/HCFA/American Public Welfare Association (APWA), Monitoring Risk-Based Managed Care Plans: A Guide for State Medicaid Agencies.

U.S. DHHS/PHS/SAMHSA, Managed Care Initiative Quality Improvement Publications: "Managing Managed Care: Quality Improvement in Behavioral Health."*

U.S. DHHS/PHS/SAMHSA, Managed Care Initiative Technical Assistance Publications: Volume One, "An Evaluation of Contracts Between Managed Care Organizations and Community Mental Health and Substance Abuse Treatment and Prevention Agencies."*

U.S. DHHS/PHS/SAMHSA, Managed Care Initiative Technical Assistance Publications: Volume Two, "An Evaluation of Contracts Between State Medicaid Agencies and Managed Care Organizations for the Prevention and Treatment of Mental Illness and Substance Abuse Disorders."*

U.S. DHHS/PHS/SAMHSA, Managed Care Initiative Technical Assistance Publications: Volume Seven, "Technical Assistance Publication Series (TAP) 22: Contracting for Managed Substance Abuse and Mental Health Services: A Guide for Public Purchasers."*

Websites: www.hcfa.gov, www.ahcpr.gov or outside organizations such as www.ncqa.org, www.nashp.org, www.samhsa.gov, www.apwa.org.

*Document can be ordered through the National Clearinghouse on Alcohol and Drug Information (NCADI) 800/729-6686 or found on the SAMHSA Web Site at www.samhsa.gov/mc/TAS.htm.